DHMH 17 Rev 7/2009

3101

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Physician/ may Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbi Howar General 8. Date of Birth (Month, Day, Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) D.C. **Funeral** Months Hours ^{Year} 1938 73 Jan. Director 577-50-9124 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland event, the Medical Examiner must be notified at Director 1 Yes 2 X No Fulton MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o Funeral items 23a USA 20759 8505 Beaufort Drive within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. 5 þ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify:White If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Law Enforcement 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Effie Alma Tavenner Richard Lee Simmonds pe permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic & once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8505 Beaufort Drive, Fulton, MD 20759 Doris Simmonds/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) May 5, 2011 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Union Cemetery 4 Donation 5 Other (Specify) Burtonsville, MD 21. Signature of Juneral Service L Prancis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring,MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events P To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Dav Pregnant at time of death Unknown Yes 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate Pompleted filled in by the funeral director, page 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita 1 Yes 2 No Other: ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural work 5 Pending 2 🗌 No Accident Investigation 3 Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certify ing Nurse Fractioner: To the best of my h at the time, date and clane, and due to the 29b. Signature and title of 29d. Date signed (Month, Day, Year) 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUZAN AND WD 10910 LiTTLE 31. Date filed (Month, Day, Yea State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland					and M	lental Hy	giene	001		000
			state Registra AMEND#19aperFH, 1. Decedent's Name (First, Middle, Last)	5/11/11;BMW,McCo	Cer	tificate	of D	eath		2. Date of Dea	Reg. No.	2111	16	PH3
	Physicia Medic		Isaak	Shkiller						Month April		2011 Year	3. Time of 1:58	
	Examin		4a. Facility Name (if not institution, give st		4b. City, Town, or Location of Death					County of Dea				
1			Hebrew Home of gr 5. Social Security Number 6. Sex			Roc If Under	cvil	Le If Under:	24 Hrs	8. Date of Birt	<u></u>	Montgo	mery rthplace (State of	- Foreign
	Funeral Director		213-47-6700	7. Age (<i>ln yr</i> s. <i>la</i> 86	Yrs.	Months	Days	Hours	Min.	12/22/		9. Bi	Ukraine	or Foreign
	d d] _	Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Loc	eation							10d. Inside Ci	ity Limits
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	or 28g	Dire	Md. Montgome 10e, Street and Number	ry G	aither	10f. Zip					10a. Citi	zen of What C	ountry?	
	with th	Funeral Director	17060 King James	Way #301			2087	7				US	•	
0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Tis marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	I2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	li li	Vas Deced Yes, spec	fy Cubar	, Mexican	, Puerto I	cify Yes or No- Rican, etc.)		14. Race - Am Black, Whi Specify:		
Maryland 21215-0036	nin 72 hou ne. than "nat e Medica	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Seconday (0-12)		life. Do	kind of wor O NOT use	k done di retired)	ition uring most	t of workii	ng		nd of Business	s Industry	
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an C	oe file rintal F ced of		17. Father's Name (First, Middle, Last) Moshe Chaim Shki	11er						e (First, Middle, rshtein		surname)		
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<u> </u>	it. Pag irtmen irtant: injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice		ean Me					/1/2011	0	lney, N	/d.	
a a	permit. Page 1 a Department of H Important: If ite any injury or ott		Edwar	rd Sagel Moo9	10		l Sa Rock	gel E Ville	uner Pik	al Dire		on , Md.	20852	
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	Medical Examiner		resulting in death)	Due to (or as a consequ										
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	ificate ig phy as the	Med	IF FEMALE:	10.2							-1			
P.O. Roy 687	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending placempleted filled in by the funeral director, page 2 should be detached for use as the completed filled in the funeral director.	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	aldeath 3	Ectopic Other (sp		у			1/4.11	23d. Date of d Month		Year
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پُ و	nding Ph tth. : After thi	cate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	2	Bc. Injury work' 1 🔲	at ? Yes 2 🗆	- 1	28d. Describe I	how injury	occurred		
ivició	l or Atte after de Directo	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		eet, factor	, office			28f. Location (City or Tov			Rural Route Num	ber,
L	e Hospita 124 hours e Funeral	Medical	(Check 2 Medical Examin	cian: To the best of my knowler: On the basis of examination	n and/or inves	tigation, in	ny opinio	n, death o	ccurred at	the time, date	and place	, and due to th	e cause(s) and m	anner stated
	To the vithir To the Comp	2	29b. Signature and title of certifier			290	. License	number	7 l		29d. Da	te signed <i>(Mor</i>	nth, Day, Year)	
			30. Name and address of person who co	empleted cause of death (Item	1 23a) (Type, F	Print)	Rock	487 Will	, , !	mD 2	085	3	-1	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 3 2011	32. Registrar's Signa	ture La	N.	-0		~ / '	-		<u></u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 28^{Day} Physician/ April 5:00 am Lam Thien Truong Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2212 Wimbledon Circle Silver Spring Montgomery If Under 1 Year If Under 24 Hrs Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 🛛 M 2 🗆 F Months Hours 1/27/37/1930 218-33-6267 China 80 Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must hα πατίπαλ α 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2212 Wimbledon Circle 20906 China 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: Completed 3 Divorced Chinese Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Garment Company Tailor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Tong Truong Thi Tran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2212 Wimbledon Circle, Silver Spring, MD 20906 Maria Truong - Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cem. 05/02/2011 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, MD 20904 11800 New Hampshire Ave., Silver Spring, 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Cardio Respiratory Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine an and To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been simpled. Cause (Disease or linjury that initiated events resulting in death) Last Hupertension Due to (or as a consequence of) attending physician a for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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Registrar
DHMH 17 Rev 7/2009

University Blvd., East, Silver Spring, Maryland 20901

M.D.,

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Registrar's Signa

Hoang Truong,

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Medic	al	Rene Alberto Tr 4a. Facility Name (if not institution, giv				4b. City, Town	or Locatio	on of Dooth	April			Αм
	Examin	er	Randolph Hills Nu				Silver				4c. County of Montg		
	Funeral Director		578-60-1412	Sex 7. Ag 1 x M 2 □ F	e (In yrs. Ia	ast birthday) 2 Yrs.	If Under 1 Yes Months Day		der 24 Hrs. s Min.	8. Date of Birth (Month, Day Feb . T.	3 , 1929	Birthplace (State or For Country) Boliv	
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	with the s 23a or ust be n	eral D	10e. Street and Number 3212 Gleneagles	Drive, #1	L09G		10f. Zip Code	0906			10g. Citizen of What USA	at Country?	
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Baltimore, Maryland 21215-0036	l be filed wi fental Hygie rked other tic event, t	To Be (12 17. Father's Name (First, Middle, Last) Carlos Troncoso			riioc	ographe	18. Mc		(First, Middle, I Lozada	Maiden Surname)	urname)	
Mary	d 2 should alth and M 1 27 is ma er traumal		19a. Informant's Name/Relationship (Laura R. Troncos			19b. Mailing Address (Street and Number or Rural Route Num.) 3212 Gleneagles Drive, #1090				#109G,	City or Town, Stat	e, Zip Code) Spring, MD 20	906
imore,	Page 1 an nent of He ant: If item ury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 4/29/11 20c. Location - City or To cemetery, crematory Alexandria,										
Balt	permit Depart Import any inj		21. Signature of Funeral Service Licer	See Aveva	6	500 500	Name and Add ancis Unive	ress of Fac J. Co. Sity	llins Blvd.	Funeral W., Si	Home In 1ver Spr	c. ing, MD 2090	01
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-	Medical Examiner		resulting in death)	Due to (or as a		,	r Throm	oosis				yrs	
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Division	ital or Att urs after d ral Direct lled in by		4 Homicide determined		ry - At hor :. (Specify)	ne, farm, stre	et, factory, offic	е	2	28f. Location (Si City or Town		or Rural Route Number,	
	the Hosp thin 24 ho the Fune mpleted fi	Medical	(Check 2 Medical Examonly one) 3 Certifying Nur	sician: To the best of iner: On the basis of ex se Practioner: To the	kamination	and/or investi	gation, in my op eath occurred at	inion, death the time, d	occurred at at at at and place	the time, date ar e, and due to the	nd place, and due to cause(s) and mann	the cause(s) and manner ser as stated.	stated.
	P \$ P 85		29b. Signature and title of certifier) and		<i>Y</i>	D3	nse numbe			29d. Date signed (A April 2	9, 2011	
			30. Name and address of person who Suresh Gupta, MD	completed cause of de 11119	eath (Item Rockv	23a) (Type, P ville I	ike, #1	.05, I	Rockvi	11e, MD	20852		
	Stat	е	31. Date filed (Month, Day, Year)	2. Registra	r's Signatu	re Las	18					·, · · · · · · · · · · · · · · · · · ·	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . Day 20<u>11</u> April 27, Physician/ 20:20 pM Vaytsner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital 9. Birthplace (State or Foreign Country) Poland If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5 Social Security Number 7. Age (In vrs. last birthday Funeral 1 □ M 2**X**] F 0371571917 Director 94 521-95-5227 Usual Residence of Decedent 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No Gaithersburg MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 20877-3649 17112 Queen Victoria Ct Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. If Yes. Give 3 ₺ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) al Hygiene. I other than " College (1-4 or 5+) Own Home Homemaker event, Be permit. Page 1 and 2 should be filed Department of Heath and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tema Woravska 0 Noah Garberman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17112 Queen Victoria Ct, Gaithersburg, MD 20877-3649 19a. Informant's Name/Relationship (Type, Print) Tema Bogachek - Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carden of Kememberance Burial 2 ☐ Cremation 3 ☐ Removal from State 05/01/2011 Clarksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Chapel, Inc. Chapel, Inc. 1170 Rockville Pike, Rockville, MD 20852 Signature of Fun 23a Part 1 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Enysician/ a <u>Anemia - acute</u> blood loss disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Radiation Cystitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) 'al-transit The law requires that the death certificate be executed Pneumonia Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 X No sate has been signed by the atte page 2 should be detached for Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Chronic respiratory failure, on ventilator, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an tracheostomy, atrial fibrillation, coronary artery autopsy performed?

1 Yes 2 No disease, sacral decubitus, severe malnutrition 1 Yes 2 No this certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: P 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys.

within 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 \sum Yes 2 \sum No iniury 1 🕅 Natural 5 Pending Investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Road

MAY 03 2011

31. Date filed (Month, Day, Year)

10068681

4

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DOROTHY LOUISE WILLIAMS APRIL 30^{ay} 20¹1 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CASEY HOUSE HOSPICE MONTGOMERY ROCKVILLE Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Days 09/09/1913 WASH. Yrs Director 97 578-05-7681 Usual Residence of Decedent 28a-f shov 10a State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD MONTGOMERY POOLESVILLE 6 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 19514 FISHER AVE. 20837 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cultan, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. o þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify "natural", 3 ☑ Widowed 4 ☐ Divorced Specify: WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) PROOF READER PRINTING 2 should be filed with h and Mental Hygien 7 is marked other tt traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ ELMER LEE HARDING GRACE CLEVELAND MULLICAN 19a. Informant's Name/Relationship (Type, Print) GRAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once, DENISE HABIB / DAUGHTER 19514 FISHER AVE., POOLESVILLE, MD 20837 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State southern"Memortal 05/05/201 DUNKIRK, 4 ☐ Donation 5 ☐ Other (Specify) GARDENS Service Licensee 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE. 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) OVARIAN CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical death certificate be Box 68760 attending IF FEMALE: nse (23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No Month Dav the 9 Unknown Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 2 No After this certificate 1 Tes Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Nother (Specify)HOSPICE Division of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending 2 Accident 3 Suicide 2 🗌 No Investigation To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🖊 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

DC

1 Yes 2 No

Year

MD 20855

8:15P

State Registrar 29b. Signatere and title of certifie

DEBRAH MILLER,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

6001

32. Registrar's Signature

news

DHMH 17 Rev 7/2009

29c. License number R143201

MUNCASTER MILL RD., ROCKVILLE,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 27 Day 2011 Year Charles Wyatt 9:34 р.м Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Frederick Memorial Hospital Frederick Frederick Social Security Number Funeral If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Days 1 🔀 M 2 🗆 Hours Director 85 Virginia 227-24-5351 1926 Feb Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural" or item———
any injury or other trainmain. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick Frederick 1 X Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 1131 Young Place 21702 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married 1946-1972 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: white Completed 3 Widowed 4 Divorced Specify 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Military Police U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Cayne Wyatt Dovie Austin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kui Wyatt - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 🖾 Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Frederick, Maryland Signatur of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between shock, or heart failure. List only one cause on each line Priysician/ Medical Immediate Cause (Final Onset and Death orman disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy After this certificate 1 Yes 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 **N**o Other: မ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Naturai 5 Pending 1 Tes Accident 2 🗌 No 24 hours after deat Funeral Director: filled in by the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1)47101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 45 Thomas Johnson Drive, Frederick, Maryland 21702 10 + IVA Wing Tan

DHMH 17 Rev 7/2009

Registrar

State

31. Date filed (Month, Day, Year)

APR

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month WIDDOWSON DHNL 14 31_ PM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BANVIEW)OHW) HOPKINS MEDICAL BALTIMORS N/A Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, Aug 17, **Funeral** 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign 1 M 2 XF Hours Year) 949 **Director** 217-52-5129 WV Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Dundalk 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 30 York Way 21222 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 X Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Support Tech JHU Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown James Bowlan Delphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Peters/son 941 Winchester Drive, Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 December 2 Removal from State 4 Donation 5 Donation 5 Removal from State Carroll Cremation 5/2/2011 Hampstead, MD of Furieral Service Lice 22. Name and Address of Facility Pritts Funeral Home & Chapel Signature 412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line nterval Between Immediate Cause (Final Onset and Death Pnysician/ Septic Shock disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner er, tonitis days Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or linjury signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery ☐ Live Birth 2 ☐ Fetal geal ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ To the Hospital or Attending Physician: The law requires within 24 hours after death. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy performed? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 No Investigation Could not be 24 hours after death Funeral Director: Suicide filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2

To the F

complet 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WJL RES-000 28 2011 APRIL 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. (.30BIND 4990 EASTERN OVENDE BATTIMORE 21224 31. Date filed (Month, Day, Year) 32. Pégistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 01, 2011 ar James T. Wong 11:40a.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye March 24 **Funeral** 9. Birthplace (State or Foreign 1 X M 2 D F Days Country) Director 228-82-4136 79 Yrs China Usual Residence of Decedent or 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 Tyes 2 X No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 4912 Aspen Hill Road 20853 u.s.A. 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 X Widowed 4 Divorced Asian event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Ches Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Chi Kau Wona Department of Health and Men Important: If item 27 is marke any injury or other traumatic Sau Lan Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tony Wong - Son 4912 Aspen Hill Road, Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Gate of Heaven Cem. 05/07/2011 | Silver Spring, MD tur of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 236. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or treat failure. List only one cause on each line.

Immediate Cause (Final Interval Between Respiratory Physician Onset and Death Failure minutes disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events soulding indeet). Examine Due to (or as a consequence of): ne attending physician and Hospital or Attending Physician: The law requires that the death certificate be executed ancer Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed' Yes 2 4 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No Other: ဂ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural iniury 5 Pending 2 Accident 3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npleted 1 (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2
To the 1 29c. License number D 65132 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

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31. Date filed (Month, Day,

MD

Records, P.O. Box 68760

Division of Vital

300

Medical

Rockville, MD 20850

9901

Registrar's Signat

19a. Informant's Name/Relationship (Type. Print) - \$13 ter | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phelps AVE., Glenn Burnie, Md. 21060 20c. Location - City or Town, State Salisburg FUNEral Somerset AVE, Princess Anne Ma. Approximate Interval Between Onset and Death 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 057952 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Milford St. #504B Salisbury, Md 21804 Babulal Das 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 04 2011 Denve S. parls **ORIGINAL**

Year

338 M

9. Birthplace (State or Foreign Country)

Baltimore

10d. Inside City Limits

1 Hes 2 No

State

Registrar

To the

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 11: 22 A M SELENA C. WEBSTER ()4 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WICOMICO at the lisblere pastal Hospice lake 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 11/16/1916 1 🗆 M 2 🗶 F Months Davs Hours Min Maryland 214-36-5152 Director 94 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Maryland Somerset Crisfield 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3067 Lawsonia Road 21817 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2X No Specify. White Specify 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Employee** 12 U. S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Willie Thomas Ruth Northam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Daniels (Daughter) <u> 3067 Lawsonia Road - Crisfield, MD 21817</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State 4 Donation 5 Other (Specify) Johns Church Cem. 04/29/2011 Deal Island, MD 22. Name and Address of Facility Bradshaw & Sons Funeral Hom 306 W. Main St. – Cristield 0 Home Robert H. Bradshaw. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between DEMEN Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions, Examiner Dire to (or as a consequence or) cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? e has b 24a, Was an autopsy performed After this certificate 2 7 No 1 Tes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) Residence 6 \(\text{Other (Specify)} \) ျ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural Accident 5 \square Pending Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 130

SAVIBULY

2/202

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hugan

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Montal United as

			For State		State of M	arylan				nd Mental H	lygiene	0 1 1	10010
			Registrar 1. Decedent's Name (Fig.	irst, Middle, Last)		Cer	tificate of	Death		Reg. No.	-	16013
	Physi Me	cian/ dical	James A.	ntonio	Willian	ns J	Jr.			2. Date of Month			3. Time of Death
4	Exan		4a. Facility Name (if not	institution, give s	treet and number)			4b. City, Town, o	r Location of	April	30°,	2011	1701 M
			Holy Cros	s Hospit	a1				er Spri			inty of Death	7
	Funer		5. Social Security Numb	0.00%	7. Age		st birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of I	Birth	0 Right	loop (Ct-t F)
	Directo		None Usual Residence of Dec		JWI Z LI F	0	Yrs.	Months Days	Hours 2	April	^{Day} (J ^{ear)} 201	1 Mary	land
	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ě		b. County		10c. City	, Town or Loca	ation					
	Maryl 28a-f ptifiec	Director	MD	Montgome	ery		coma Pa					1	0d. Inside City Limits
	a or 2	0	10e. Street and Number					10f. Zip Code			10- 0:4:	- f.W/- 1 O	1 K Yes 2 No
	h with	Funeral	6609 Popla	r Avenue	2			20912	2		USA	of What Coun	try?
	r item	T.			2. Was Decedent En	ver in U.S.		as Decedent of H	ispanic Origin	? (Specify Yes or No		ace - America	an Indian
36	after after al", o	d by	1 X Never Married 3 Widowed 4		1 Yes 2 V	No	1 "	res, specify Cuba ⊒Yes 2 1 € No	in, Mexican, F	uerto Rican, etc.)	В	lack, White, e	tc.
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pu	filed tal Hy dott	To Be	17. Father's Name (First,	,					18. Mother's	Name (First, Middle	Maiden Surna	mel	
<u> </u>	Men Men narke	٦	James Will						Maria	h Owens	, maideri Sarria	me)	
Mai	shou h and 7 is n		19a. Informant's Name/R				19b. Mailing	Address (Street a	nd Number o	r Rural Route Numb	er. Citv or Town	State Zin Co	nde)
ė	and 2		Felicia Wi		Grandmot	her	6609	Poplar A	venue,	Takoma I	ark, Ma	ryland	20912
Baltimore, Maryland 21215-0036	nt of int of int of int of or		20a. Method of Disposition	emation 3 🗆 Re	emoval from State	cer:	ce of Disposit	on (Name of	a)	Date		n - City or Tow	
Iţi	nit. Pa artmen ortani njuny		4 □ Donation 5 □	Other (Specify)		Ches	apeake	Cremato	ry Ma	y 5, 2011	Beltsv:	ille, N	Maryland
Ba	permit. Page 1 a Department of H Important: If ite any injury or ott		21. Signature of Funeral	ervice Licensee			22. N	ame and Address	s of Facility	Johnson δ	Jenkin	s Fune	ral Home
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	Dhysisian		23a. Part 1. Enter the dis- shock, or heart failu Immediate Cause (Final	re. List only one	cause on each line.	ne death.	Do not enter t	ne mode of dying	, such as card	diac or respiratory a	rest,		Approximate nterval Between
	Physician/ Medical		disease or condition resulting in death)	a.	PRETERM	PREMA	ATURE F	UPTURE (OF MEM	BRANES			Onset and Death
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687	artifica ling p e as t		IF FEMALE:										
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_	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4 Pregnant at tir	me of deat		her (specify)			M	onth Da	ay Year
P.0	that the ned by the detach	P	Part II. Other significant o	onditions contril	buting to death but r	not resultir	a in the unde	hying cause giver	n in Don't				
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orc	v require s been si should b	olete								- 10	es 2 KL No	3 ∐ Probab	ly 4 🗆 Unknown
Records,	The law requires ate has been sign page 2 should be	m o								24a. Was a autop	sy	prior to compl	findings available letion of cause of
al F	s ician: The certificate irector, pag		5. Was case referred to me	edical						perfor	med?	death? 1 🗌 Yes 2 [
of Vital	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificated filled in by the funeral director,	<u> </u>	examiner? 1 Yes 2 No	Hosp	oital:	0 🗆		Othor:		eck only one)			
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ion	ttendii Jeath. tor: Af the fu	fica	2 Accident I	Pending Investigation	(Month, Day, Ye	ear)	injury N	28c. Injury at work? 1 1 \(\sum \) Ye.	s 2 🗆 No	28d. Describe ho	w injury occurr	ed	i
Division	or Att fter d irect n by	Certificate:		Could not be determined 2	28e. Place of Injury - building, etc. (S)	At home,	farm, street, f			28f. Location (St	reet and Numbe	er or Rural Roi	ete Number
	ortal o	<u>a</u>				101				City or lowi	, State)		ne wamper,
:	No the Hospital or within 24 hours after To the Funeral Dire Completed filled in b	Medical	9a. Certifier 1 🛣 Certifier (Check 2 🗌 Med	tifying Physician	To the best of my l	knowledge	e, death occur	ed at the time, da	ate and place,	and due to the cau	se(s) and manne	er as stated.	
	of the		only one) 3 Cert 9b. Signature as 4 title of cert	tifying Nurse Pra	actioner: To the best	of my kno	wledge, death	occurred at the tir	ne, date and p	d at the time, date an lace, and due to the	d place, and due cause(s) and ma	to the cause(s	s) and manner stated.
	- > - 8		Signature and traile of d	artifler .	10-			29c. License nu	ımber		9d. Date signed	(Month, Day,	
Ţ		-	Nome and		(1-)			D44792			04/30,	/2011	
R	2	1	O. Name and address of pe	mson who comple	eted cause of death	(Item 23a)	(Type, Print)	· · · · · · · · · · · · · · · · · · ·	- 01	D- 1 0:5	-		1 00011
	State	3	Darryn Band, Date filed (Month, Day, Y	'ear)	32. Regietra o	iosp1	cal, I	ou Forest	Glenn	Koad, Sil	ver Spr	ing, M	d 20910
	Registra		MAY 0 5 20		32. Registrar's S	400				t			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 1,2011 Day Year Sarah White 350 pm Medical 4a Eacility Name (if not institution, give street and number)
12613 Meadowwood Dr 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 579-54-6628 1 □ M 2 🕱 F Months Hours 93 Director New York Feb 20.1918 Usual Residence of Decedent 28a-f shov 10b. County with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 12613 Meadowwood Dr 20904 permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 5 + yrs Elementary/Seconday (0-12) Instructor School School Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname)
Geraldine McDora ပ John Alvin Ross 19a. Informant's Name/Relationship (Type, Print) Virginia Brown-Nolan 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State, Zip Code) 12613 Meadowwood Dr Silverspring MI 20904 RIVERDALE, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗆 Burial 2 🙀 Cremation 3 🗀 Removal from State Donation 5 Other (Specify) Signatu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician Dementi disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Kenson Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medica examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 AResidence 6 Other (Specify) မ 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 \(\sum \) Yes Certificate: 28d. Describe how injury occurred Natural iniun 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kouerchou, Jocelyne 163748

Registrar
DHMH 17 Rev 7/2009

State

4041 Powder Mill, Road Bitsville, MD 20705

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Ocelune Kouatchou

Date filed (Month, Day, Year,

MAY 0 5 2011

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31. Date filed (Month, Day, Year)

Director

Completed by Funeral

Be

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Examine

Be Completed by Physician/Medical

Certificate: To

Medical

Physician/

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Director

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. Decedent's Name (Fi	rst, Middle, Las	st)						2.	Date of Dea Month		Ye	ar	3. Time of Death
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6347 Geno Social Security Numb	er 6. S	ex 7.	Age (In yrs. la		If Under 1		Landin If Under 24 Hrs Hours Min.	. 8.	Date of Birth	1	Anne 1	Birthp	lace (State or Foreign
78-16-163 ual Residence of Dec	/	- M 2 W	91	Yrs.				C	07-28-1	919	Wa	Count ash	", D.C.
	b. County		10c. City	y, Town or Loc	ation							1	0d. Inside City Limits
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Charles	Beniam	in Boi	tzell								l1er		
a. Informant's Name/			rzeri	10h Mailin	a Address /	Stroot a	Janie nd Number or Ru		larie			Zin C	anda)
Charles L		,		1			t, Hano			1733		, <i>zip</i> U	ode)
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1 Burial 2 C 4 Donation 5 D			ate	emetery, crem			· :						
Signature of Funera			עמן				ery 05- s of Facility Ra				ltenh		
11) 1 lig	in R	-RN					[armony]						
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quentially list conditi any, leading to immeduse. Enter Underlying use (Disease or iinjuat at initiated events sulting in death) Last	diate g	c	as a consequ						or cu	140	30		
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t II. Other significan	nt conditions co	ontributing to dea	th but not resi	ulting in the ur	nderlying car	use give	en in Part I.		23e. Did to	bacco us	e contribut	e to th	e cause of death?
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Was case referred to examiner?						26. Pla	ce of Death (Che	ck on					
1 ☐ Yes 2 ☑ No	0	Hospital: 1 🔲 In	patient 2 🗆	ER/Outpatient	3 🗆 DOA	Other	: 4 ☐ Nursing H	lome	5 Reside	ence 6 [Other (S	oecify)	
Manner of Death Natural 5 Control Manner of Death	Pending Investigation	28a. Date of injury 28b. Time of injury injury				work?	Injury at 28d. Describe how injury occurr						
3 Suicide 6 4 Homicide	Could not be determined		me, farm, stre				28f. Location (Street and Number or Rural Route Number City or Town, State)				Route Number,		
(Check 2 ∐ I	Medical Exami	sician: To the bes ner: On the basis se Practioner: To	of examination	and/or investi	gation, in my	opinion	, death occurred	at the	time, date an	d place,	and due to t	he cau	se(s) and manner state
o. Signature and title	of certifier	_	1,00	inc			number 5 0 6 5 3	2	2	9d. Date	signed (Mo	onth, E	

DHMH 17 Rev 7/2009

State Registrar

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32. Registra s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>011</u> Physician/ April 27 06:10 AM Zippin Medical 4a. Facility Name (if not institution, give street and number)
Renaissance Gardens
at Riderwood **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 055-14-7579 1 □ M 2X□ F Hours Country) 1073074918 Director 92 NY Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director D.C. Washington 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 520 13th St SE 1/2 Unit A 20003 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 Z No Specify: White Specify: other than "natural", 3 XWidowed 4 ☐ Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) New York State Elementary/Seconday (0-12) College (1-4 or 5+) 4 Bookkeeper Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked be Henry Schacter Anne Eisen permit. Page 1 and 2 should Department of Health and M. Important: If item 27 is marl any injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 520 13th St SE 1/2 Unit A Washington, DC 20003Jeff Zippin - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Hebron Cemetery 04/29/2011 Flushing, NY 22 Name and Address of Facility Danzansky-Goldberg Memorial Chapels Inc 1170 Rockville Pike KOCKVILLE MD 20852 21. Signature of Funeral Service Li 23a. Part 1. Enter the disease, or complications that caused shock or hartfailure. List only one cause on each line. ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a. Coronary Artery Disease Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trans Atrial Fibrillation s been signed by the attending physician and should be detached for use as the hurral-then that initiated events resulting in death) Last Due to (or as a consequence of) cal Division of Vital Records, P.O. Box 68760 by Physician/Medi IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Polymylagia Rheumatica 1 Yes 2 No 3 Probably 4 Unknown Completed Chronic Kidney Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an has autopsy performed? Yes 2 X No page 2 After this certificate Anemia 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) B Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital မှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at X Natural 5 Pending injury work?
1 Yes 2 No death. 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director:

Completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D44156

State Registrar 31. Date filed (Month, Day, Year)

MAY 03 201

3110

2. Registrar's Sign

Grace field

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me, g915,05/17/2011 dill Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Athey 9:44PM Noreen 04 Dorothy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Anne Arundel Medical Center 6. Sex If Under 1 Year If Under 24 Hrs . Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours (Month, Day, Year) 04/07/1928 1 M 2 X F 83 MD Director 212-26-9481 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at rector 1 Yes 2 XNo Centreville Oueen Anne's MD 靣 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral items 23a U.S.A. 21617 205 Opera Court death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ö 1 Never Married 2 Married þ Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Package Goods 12 Business Owner event, Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 0'Lexey Babicky permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e Elizabeth traumatic .Iohn Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessup, MD 20794 2071 Shipley Farm Road Mrs. Cathy Pritchard / Daughter Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of May Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 2011 Glen Burnie, MD 4 Donation 5 Other (Specify) Atlantic Crematory 22. Name and Address of Facility 1 21. Signature of Funeral Ser 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, 23a. Part 1. Enley the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying CERTIFICATION APPROVED BY MEDICAL EXAMINER Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last requires that the death certificate be executed burial-transit and Due to (or as a consequence of): nding physician ause as the burial-Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day for Month Year 5 Other (specify) Pregnant at time of death ned by the a detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I ρ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: The law this certificate has ral director, page 2 autopsy performed? Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be niner? examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at After 1 Natural injury 5 \square Pending work? 1 ☐ Yes 2 ☐ No death. n 24 hours after death.

e Funeral Director: A pleted filled in by the fu Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a, Certifiei Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 the the only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Goulet 000 31. Date filed (Month, Day, Year) Registrar's Signature 32 State MAY

ORIGINAL

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death LEN MABEL Physician/ Month 16145P.M Medical 4a. Facility Name (if not institution, give street and number) 5401 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Itimo re old Court Ad 5. Social Security Number Birthplace (State or Foreign Country) last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 F 9-30-00 Director Usual Residence of Deceder show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 1 Yes 2 No Specify 3 Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should Department of Health and M Important: If item 27 Is mar 19a. Informant's Name/Relationship (Type, Print) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State semetery, crematory or other place injury 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician NEUMONIA disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day 1 Yes 2 9 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CARDIOMYOPATHY. CHOROMC 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an as S ieral Director: After this certificate har filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Ves 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) within 24 hours a

To the Funeral C

completed filled Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RANGARAOM AMASWAM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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s after deal ral", or iter Examiner	\$	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates.	lf	13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 □ Yes 2 X No Specify:			14. Race - An Black, Wh Specify: A			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)	ation	(Give k	ent's Usual Occupa ind of work done du NOT use retired)	uring most of worki	ing 16b	b. Kind of Busines	s Industry		
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	3	19a. Informant's Name/Relationship (Type Frank Paek/Son	, Print)				PROUTE Number, City				
		20a. Method of Disposition 1 ☐ Burial 2 🗶 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State B	o. Place of Dispos cometery cremon altimore Cremato	e Washing	ton 4/15	Date 200 /2011 La	Location - City aurel, M			
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To the Hospital or Attending Physician: The ka within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical ((Check 2 Medical Examine	an: To the best of my kno	owledge, death o tion and/or invest	igation, in my opinior	date and place, an	d due to the cause(s	and manner as ace, and due to the	stated. se cause(s) and manner stated		
To the I within 2 To the I comple	_	29b. Signature and title of certifier	dde	W.>	29c. License			Date signed (Mo.			
le		30. Name and address of person who com	pleed cause of death (It	em 23a) (Type, P	rint) OSKY	Drive	Taus	on M	0 01204		
Sta Registi		31. Date filed (Month, Day Year) 7	32. Registrar's Sig	nature	Parket		-				

State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day DOI Physician/ 4.05 P M CHARLES EDDIE BURGESS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death THINE MENLA BALTIMORE WARHINGTON 8. Date of Birth Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F 38 Yrs. 5172 **Director** 216 86 Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Ves 2 No MD Anne Arundel Glen Burnie r items 23a or ner must be n ö 10e. Street and Number 10g. Citizen of What Country? Funeral 261 21060 Carroll Rd. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ò 1 Never Married 2 Married þ and Mental Hygiene. is marked other than "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Diesel Technician Trucking Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Nancy Coombes Charles E. Burgess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21060 Candace R. Burgess - Wife 261 Carroll Rd Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗀 Removal from State Crematory 5/11/11 4 ☐ Donation 5 ☐ Other (Specify) Bayview Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GJ Gonce Funeral Home PA169 Riviera Drive Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ MIRTACTATIO disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if the sequential sequence is cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Examir physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death g ☐ Unknown 5 Other (specify) ed by the detached 9 Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? within 24 hours after death.

To the Funeral Director. After this certificate homoleted filled in by the funeral director, pag-1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 🗷 To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospita 1 Yes Other: 2 No I Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man or of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 2011 completed cause of death (Item 23a) (Type, Print) Lleu Burnie Hospita 32. Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Marguerite Cecilia Brown May 8:13 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 35 Oak Avenue Cecil <u>Earleville</u> If Under 8. Date of Birth (Month, Day, May 9 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Maryland Days Min. 1 □ M 2 👿 F Months Hours 215-32-0578 97 Director 1914 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 🗆 Yes 2 😿 No Cecil Earleville Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 35 Oak Avenue 21919 United Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. 3 ₩ Widowed 4 □ Divorced Specify: White Year or Dates other than "natu 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Labs Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked or traumatic eve ဂ္ဂ John Auer Schuchart Marv Martha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 Whithorn Court, Timonium, Maryland 21093 George J. Brown / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05/18/2011 | Baltimore, Maryland Metro Crematory Inc. 22. Name and Address of Facility Cremation Society of Maryland Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Ent. the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ardionyopath disease or condition resulting in death) Medical Due to (or as a conse v nce of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate Cause (Disease or linjury the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician by Physician/Medical Box 68760 attending p es, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year ate has been signed by the a page 2 should be detached it P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part !. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 2 1 Yes Yes the Hospital or Attending Physician; I hin 24 hours after death. the Funeral Director: After this certifica the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 - Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ertifie Sachder Sno D0023322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ElpTon MO 21921 thigh ST, SACHDEN

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

11-03	695
Carol	Brilhart

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Carol Brilhart		1- For State Registrar	Stat	e of Maryla		artment of e <i>rtificate of</i>		d Mental I		2 0 Reg. No.	11 16022	
Physicia Medical Exami	an/	1. Decedent's Nam	e (First, Middle,L Carol	ast)	,	Brilhart			2. Date of Dea Month May 16, 2	ath Day Year	3. Time of Death 2107 hrs	
		4a. Facility Name (if not institution,		mber)		4b. City, Town, or	Location of Dea		4c. County of	Death	
Funeral		5. Social Security N		Medical Cent	7. Age (In yrs.	last birthday)	Baltimore If Under 1 Year	f If Under 24H	rs. 8. Date of Bi	Birth(MM/DD/YYYY) 9. Birthplace (State or		
Director		220-36-6	171 1	M 2_ _ F		71 Yrs. Months Days Hours			in. Decembe	Foreign Country) Maryland		
Any		Usual Residence o 10a. State	f Decedent 10b. County		10c. City	, Town or Locat	ion				10d. Inside City Limits	
	5	Md.	Ba	altimore			Dunda.	lk			1 Yes 2 No	
e Maryl	Director	10e. Street and Nu		ltimore	Stroot		10f. Zip Code	11 22 4		10g. Citizen of Wha		
with th ns 23a be notif	- 1	11. Marital Status		12. Was Dec	edent Ever in L		s Decedent of His			o- 14. Race -	USA American Indian, Black,	
r death	Funeral		ed 2 Marri	1 Yes	2 X No		es, specify Cuban		to Rican, etc.)	White,		
ours afte	d b	3 Widowed 15. Decedent's Ed		ed If Yes, Give Year or Dates: only highest grad		16a. Deceden	Yes 2 No t's Usual Occupati	ion (Give kind o		Specify:		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medikal Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired to the control of the control							etired)	Own	n Home	
5-0036 ited within 77 Hygiene. I other than	S	17. Father's Name		st)		<u> </u>			ne (First, Middle,	Maiden Surname)		
2121 vuld be fil Mental H marked	B B	Richard Mabus Katherine Schaffe									er State Zin Code)	
MD 2 12 shou th and N 27 is n	٩	Milford			lusband		•			Baltimore	, Md. 21224	
MOFE, Pages I and tent of Heal		20a. Method of Dis 1 Burial 2	<u>-</u>	3 Removal fro	om State	Place of Dispos crematory or oth	ition (Name of cen ner place)	netery, Ma	Date y 21,	20c. Location - C	City or Town, State	
Baltimo permit. Pag Department Important: injury or of		4 Donation 5 21. Signature of Fy			0a		Cemetery ame and Address		2011	Duridati	k, Maryland	
		(Int	and.	(elli	1/ C	onnelly 110 Soll	Funeral	Home Of	Dundalk,	P.A.	
Physician		failure. List on	ly one due on	mplications that ca each line. _{a.} Probable Po	•	1.)Do not enter th	ne mode of dying,	such as cardiac	or respiratory an	rest, shock, or hear	App erval Between Onset and Death	
≟xaminer		Immediate Cause (or condition resulting	ng in death)	Due to (or as a	consequence of	of):						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Bowel Perforation Due to (or as a consequence of): Due to (or as a consequence of):											
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Sox 6876 death certificate e attending phy for use as the I	ian/	23b. Was decedent past 12 months		1 Live bi		2 Fe	tal death 3 [ner (Specify)	Ectopic pregr	nancy	Month	Day Year	
BOX ne death the atte	Physician/W	1 Yes 2 🗸		9 Unikilo					I a au			
ords, P.O. B w requires that the d s been signed by the	ā	Part II. Other signi metastatic		 contributing to cinoma, high 			nderlying cause g	iven in Part I.			ute to the cause of death? Probably 4 Unknown	
rds,	Completed								24a. Was		ere autopsy findings available or to completion of cause of	
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Vital Rec ysician: The this certificate director, page	Be	25. Was case reference examiner?	_	Hospital: 1 Ir	npatient 2	ER/Outpatient	- 1	of Death (Check		Residence 6	Other:	
of Viing Physical After this	7: To	27. Manner of Deat		28a. Date of Month, May 16,	of Injury	28b. Time of I	njury 28c. Injur	y at Work?		how injury occurred		
Sion Attend r death. ector: by the f	Certification:	1 Natural 2 Accident	5 Pending Investiga	ation 28e Place		2058 hrs	1 Y	es 2 V No		Street and Number	or Rural Route Number, City	
Div pital or ours afte eral Dir filled in	jerit Fire	3 Suicide 4 Homicide	6 Could no determin	ot be	unknown	,0,110, 101111, 01101		and g, oto.	or Town, S unknown, ,			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical (29a. Certifier (Check only one)								se(s) and manner a		
To To Com	Med	29b. Signature and		and manner st	ated.		29c. License	number			(Month, Day, Year)	
		Theody	on M.	Kind	The	м. б	O.C.N	и.е. ⁰⁶	ME	May 17, 201	1	
le J		30. Name and addr Theodore M	ess of person wh I. King, Jr., W				900 W. Baltim	ore Street, I	Baltimore, MI	 D 21223		
		31. Date filed (Mont		32. Re	gistrar's Signat	ure a Kad						

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 16, Day 2011 Year May 8:30P BERNHARDT BORTELL Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 12/25/1927 89 ^cMaryland Director 215-12-7651 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X Xo Maryland | Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10881 York Road 21030 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Mantal Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 1 Yes No Specify. If Yes, Give Year or Dates Specify. White Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Childrens Leader City Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H Department of Health and Ment.
Important: If item 27 is marked any injury or other treesone. 2 Americus Gill Bortell Agnes Sophia Kaufman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Cole Niece 10508 Samona Avenue Cockeysville, Maryland 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Dulaney Valley Mem Grdns 05/23/2011 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Locense 22. Name and Address of FaMirtchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or conplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) chronic obstrictive ling disease Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): death certificate be executed Cause (Disease or linjury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical phys the attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 Mg Unknown been signed by the should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ky pertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' Yes 2 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 400 1 Yes 4 Nursing Home 5 Residence 6 Dether (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA n 24 hours after death.

E Funeral Director: After the leted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending work?
1 Yes 2 No Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (harles 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 2011

DHMH 17 Rev 7/2009

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

of Vital

Division

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 13. Michelena JoAnna Baisi 12:32 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Rockville Montgomery Social Security Number If Under 1 Year _ If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral (Month, Day, Ye ine 24, Days Hours Director 235-34-1299 Bellaire, Ohio 88 une Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If tiem ZT is an After other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville 1 ☐ Yes 2 X No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 20850 USA 307 Oak Knoll Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital 12 Registered Nurse æ Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dominick Yacovoni Rose Bissa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn Richards-Daughter 307 Oak Knoll Terrace, Rockville, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 x Buriar 2 4 ☐ ponation st. Brendan ♀ □ Cremation 3 □ Removal from State 5 Other (Specify) 5-19-2011 Elkins, WV emetery 22. Name and Address of Facility Lohr & Barb Funeral Home 120 1st St., Elkins, WV 21. Sign, ture of Fi neral Service Livense 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ACUTE ARRHYTHMIA disease or condition resulting in death) MINS Medical Due to (or as a consequence of): Examiner ACCIDENT EREBROVASCULAR MONTHS Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Exami nding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12.months?

1 Yes 2 No
9 Unknown Day 4 Pregnant at time of death 5 Other (specify) Month been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed' After this certificate 2 X No Yes 2 X No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 XNo Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of co person who completed cause of death (Item 23a) (Type, Print) 30. Name and address lesse. 9901 MEDICAL CENTER DRIVE ROCKVILLE, MD 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2011

MAY

BAISI

LENA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., g915,05/19/2011dhb

Certificate of Death

Reg. No. For A State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ SPOWN TER DUISS 02:25 PM 2011 Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death tospice Randallston Itimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Security Number **Funeral** 1 M 2 N Yrs **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Ves 2 No HMIRO 10g. Citizen of What Country? 10e Street and Numbe 10f. Zip Code Funeral 21/33 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, # Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည Far 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 361 KandallStour SWI Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation Other (Specify) 21. Signatur 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Kidney Disease disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): -transit or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last -burial attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a 9 Unknown Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 2 2 No Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Inbutient toli 2 No Other: 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending injury Accident 24 hours after death. Funeral Director: A 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 🗌 within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ TERRY LYNN BAILEY MAY 5:55 P M 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funeral (Month, Day, 1 X M 2 □ F Days Hours Min. 1946 Illinois Director 330--38-5564 64 Nov. Usual Residence of Decedent 28a-f show 10b. County ral", or items 23a or 28a-f sho Ex miner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Illinois | Moultrie Lake City 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2425 B. CR 500 East U.S.A. 61937 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 X Married Completed by Yes 2 □ No
f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Minister Clergy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed of Health and Mental H fitem 27 is marked ot ၉ James Bailey Viola Grubb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Bailey (Wife) 2425 B. CR 500 East, Lake City, IL 61937 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Hewitt Cemetery 4 Onation 5 Other (Specify) 5/17/2011 Lovington, IL 22. Name and Address of Facility McMullin-Young Funeral Home 503 W. Jackson St., Sullivan, 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) CISYSEDIC 2 minute Medical Due to (or as a consequence of): Examiner one day electrolyte abnormalit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exam metabolic actionis DIE WEELL death certificate be executed that initiated events resulting in death) Last bunial-tra Due to (or as a consequence of): attending physician for use as the burial Physician/Medical renal insufficiency five weeks 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day 1 L Yes 2 L 9 D Unknown the ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 failure nepatic inciphalopathy. 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? adrene cortical cancer grown regulive red septiamia 24a. Was an autops autopsy performed? 1 Yes 2 No ☐ Yes 2 🗓 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After t 28d. Describe how injury occurred Certificate: To the Hospital or Attending 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Director: / 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 👿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) MGY 12, 2011 256907 MT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINDY L. DAVIS 10 CENTER DRIVE, BETHESDA, MARYLAND 20892

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

17 201

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 16, 2011 12:10 A M Peter Norman Brush Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford 8. Date of Birth (Month, Day, Jan. 9, If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. 1 🔀 M 2 🗆 F Hours Maryland Director 217-60-2315 1954 Usual Residence of Decedent or 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 🗌 Yes 2 🔀 No Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1215 Deer Creek Church Road 21050 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. Completed by 1 Never Married 2X Married within 72 hours after 1 ☐ Yes 2X No Specify. "natural" 3 Widowed 4 Divorced Specify: White other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Bricklayer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o ၉ James Stanley Brush Eileen Winefred Dye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Toni Diane Brush / Spouse 1215 Deer Creek Church Road, Forest Hill, MD 21050 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If any injury or once, 1 ☐ Burial 2X Cremation 3 ☐ Removal from State ò Hilltop Service Corp | 5-19-11 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition una Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or and I-transit that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.
To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 25. Was case referred to medical Medical Certificate: To Be Division of Vital 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of ce 29d. Date signed (Month, Day, Year) odress of person who completed cause of death (Item 23a) (Type, Print) Drive Bel Air mD 21014 mD 500 State Registrar

DHMH 17 Rev 7/2009

M&0566551

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 20<u>11</u> Month May Physician/ David Allen Boboltz, Sr. 17 03:05 A^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 7517 Arden Road Cabin John Montgomery Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) December 29, 7. Age (In vrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 📉 M 2 🗆 F Months Days Hours Min Yrs Director 369-38-1059 Michigan Usual Residence of Decedent 28a-f show 10a. State 10b. County death with the Maryland 혀 10c. City, Town or Location 10d. Inside City Limits Director notified 1 ☐ Yes 2 🔀 No Maryland Montgomery Cabin John ō 10e. Street and Number 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be 1 Funeral 7517 Arden Road <u> 20818</u> United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Ever in 0.5.
Armed Forces?
1 \ \overline{X}\text{ Yes} 2 \ \overline{\to}\text{ No} \ 1957−
If Yes, Give
Year or Dates. \ 1963 Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🔀 No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working th and Mental Hygiene.
77 is marked other than traumatic event, the Me life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Local Government Civil Engineer Be pe filed √ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Fred Martin Boboltz Helen Martha Becker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7517 Arden Road, Cabin John, Maryland 20818 Ellen Beauchamp/Wife 20a. Method of Disposition UNK Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Arlington, Virginia 21. Signature of Funeral Service Licen Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Glioblastoma Multiforme Months Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi physician and Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) the a should be detact ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 X this certificate 2 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Dursing Home 5 X Residence 6 Dother (Specify) 2 XNo မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending 1 XNatural work 24 hours after death Funeral Director: A 1 Tes 2 🗌 No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 🗌 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe May 17, 2011 D23308

State Registrar Victor

M

7 2011

Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

6420 Rockledge Drive #4100, Bethesda, Maryland 20817

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

 $M \cdot D$

32. Registrar's Signatu

Priego

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 4:06AM M 16, 2011 May Ann Marie Bridges Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Atrium of Potomac otomac Montgomery 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. (Month, Day, Yea **Director** 220-56-3789 85 New York Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Potomac Montgomery ō 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Examiner must be Funeral 23a 13109 Brushwood Way 20854 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ò by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural" Specify: 3 X Widowed 4 Divorced Completed White er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Agent Title Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Michael Bruton I and 2 should b I Health and Mer Item 27 is mark Agnes Hynes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health
Important: If item 27
any injury or other to John D. Duncan, Jr./ Son 13109 Brushwood Way, Potomac, Maryland 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Acensery crematory or other place)
Artification
National Cemetery 1 K Burial 2 Cremation 3 Removal from State 22. Name and Address of Facility Robert A.

Packville, Inc. 300 West
Marvland 208. 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia Signature of Faheral Service Licensee A. Pumphrey Funeral Home/ Vest Montgomery Avenue 20850-2805 M00335 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Atherosclerotic Cardiovascular Disease Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical JE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for Month Year Pregnant at time of death 5 Other (specify) Day Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier King Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29c. License number 29d. Date signed (Month. Day, Year) H45839 May 16, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FOFACP 5413 West Cedar Lane, Bethesda, Maryland 20814 Gary Raffel 31. Date filed (Month, Day, Year) Registrar

Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland	•	rtment of H tificate of L			iene2 () 19. No.		16030
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat	h	Van	3. Time of Death
	Physici /Medic		Harold Block	24				Month 5	Day	Pear	3.15PM
•	Examin		4a. Facility Name (If not institution, give s	1 1 1		4b. City, Town, or	Location of Death		4c. Count	y of Death	
			Carpell Hos	oital lente	1	West	minster		Car		
	Funeral		Social Security Number 6. Sex	7. Age (in yrs. i	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign intry)
	Director		219-18-28/6	^{M 2□ F} 87	Yrs.	Wild Days	Trodio Nan.	12-26-	1923	MD	
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c Cib	/, Town or Lor	cation					10d. Inside City Limits
	eho	5	MD Carrol		, , , , , , , , , , , , , , , , , , , ,		minster				1 ☐ Yes 2 No
	10 the A	Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of	What Co.	unto/?
	n 72 hours efter deeth with the Maryland "naturel", or Iteme 23a or 28a-f ehow adical Examinar mast be notified at	ă	116 College V	iew Blvd		1	21158	, '	USA		muy:
	ne 23	Funeral		2. Was Decedent Ever in U.	S. 13. V	Vas Decedent of Hi	ispanic Origin? (Sc	pecify Yes or No-			ican Indian.
^	riten In	표	1 X Never Married 2 ☐ Married	Armed Forces? 1 1 Yes 2 □ No	11	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		ack, White	
3	urs e	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2☐ No	Specify:		Speci	ity:whi	te
215-0036	within 72 hours after ene. then "naturel", or Ite he Medical Erecolor	Completed	15. Decedent's Educ	cation	16a. Deced	ent's Usual Occupa	ation	king	16b. Kind of I	Business/I	ndustry
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7	filed wi Hyglen other th	Con	12		Adm	inistra					
		Be	17. Father's Name (First, Middle, Last)	1				ne (First, Middle, M	Ma <i>iden S</i> uma	me)	
<u>X</u>		ဥ	Frederick Bloe				Sarah	Eckard			
Maryland	2 8 5 5	10	19a. Informant's Name/Relationship (Ty) Barbara Holtzma			g Address (Street a					
	tem 27					College					
Baltimore,	ges 1 t of H if ite or ot		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ R	milioral illoili Otale	_	sition (Name of natory or other plac			20c. Location	,	
	tmen tent:		4 □ Donation 5 □ Other (Specify)			Park Ce			Balti		<u> </u>
ā	permit. Pages 1 Department of P Importent: If Ite eny Injury or ot ance.		21. Signature of Funeral Service License	JH 11 11		. Name and Addres					
	LUZEU		I premas .	Jamon		54 E. Ma				, PID	21157
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	e cause on each line.	1. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	COPI							
	/Medical Examiner		Tosulary in double	Due to (or as a consequ	uence of):						
		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ionce of):						
П	bed nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	derice or).						
	al-tra	xar	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):						
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200		edical		•							
XOP	death certifi e ettending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna					23d. D	ate of deli	verv
ň	et the death by the ette	cial	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of d]Ectopic pregnancy] Other <i>(specify)</i>				fonth	Day Year
j.	oy the	hys	9 Unknown	9□ Unknown							
<u>જ</u> ે	requires thet the een signed by th hould be deteche	by P	Part II. Other significant conditions con	tributing to death but not resi	utting in the ur	nderlying cause give	en in Part I.	23e. Did to	oacco use co	ntribute to	the cause of death?
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Hecord	> 0 0	olet	Atrial about	Motion				24a. Was a		. Were au	topsy findings available
	9 <u>F</u> <u>9</u>	Completed	10000					autops	ned?	death?	ompletion of cause of
Vital		0	25. Was case referred to medical		<u> </u>		26 Place of Dea	1 ☐ Yes :	2 No	T Tes	2(1No
	S O	To B	examiner?	ospital:	ER/Outpatien	t 3 DOA Oth	er	ome 5 Reside	1	ther (Spec	cify)
ō	ding Ph h. After th funeral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		v at	28d. Describe ho			,,
Ö	tendin death. tor: Aft the fur	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 1 dar)	Injury		Yes 2 □ No				
DIVISION	or de) E	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specific	ome, farm, str	eet, factory, office		28f. Location (Si City or Town		nber or Ru	ral Route Number,
5	rs aft	Certification:		Sundaring, one. (Opport)				Unit of town	., φιαισ/		
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying Phys	ician: To the best of my kno er: On the basis of examina	wledge, death	occurred at the tin	ne, date and place	, and due to the c	ause(s) and r	nanner as	stated.
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	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	D. 49	ave				*	

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			For	State of Ma	arylan			Health and I	Mental Hy	giene	0011	1 4 6 6 1
			State Registrar			Cer	tificate of	Death		Reg. No	0.6011	6031
	Physicia	ın/	1. Decedent's Name (First, Middle, La	•					Date of Dea Month	ath 17 ^{Da}	ay Year	3. Time of Death
	Medic	cal		MILDR	ED L	CHE			0 ^{Month}	+/	2011	
	Examin	ier	4a. Facility Name (if not institution, giv					or Location of Death	1	1 .	County of Deat	
	Funeral		16 Winding Wo 5. Social Security Number 6.3		e (In yrs. la	ast birthday)	Pasac If Under 1 Year	If Under 24 Hrs.	nne Ar	hplace (State or Foreign		
	Director		217 12 8183	1 □ M 2 X F	88	Yrs.	Months Days	Hours Min.	5/14/2	192	.3 Co.	MD
	d t t	_	Usual Residence of Decedent 10a. State 10b. County		10- 04	y, Town or Lo						404 1-41-03-13-3-
	a-f sh ied a	Director	MD Anne A	munda 1		saden						10d. Inside City Limits 1 Yes 2 No
	or 28	Dire	10e. Street and Number	runder	га	saden	10f. Zip Code		1	10a C	itizen of What Co	
	with ti	Funeral	16 Winding Wo	ods Wav				21122		rog. o	U.S.A	•
	tems er mu	Ē	11. Marital Status	12. Was Decedent E	ver in U.S	S. 13. V	Vas Decedent of I	Hispanic Origin? (Sc	ecify Yes or No-		14. Race - Amer	rican Indian,
98	fter d , or i	þ	1 Never Married 2 X Married	Armed Forces? 1 Yes 2	1 Yes 2 X No			If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🄀 No Specify:			Black, White	
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212	iled within 72 hours after death with the Maryland I Hygiene. other than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at	Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use retired) Office Helper Catholic									tholic	Center
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lan.	sh is		19a. Informant's Name/Relationship (**			-	and Number or Ru		-		
≥,	and 2 Health em 27 ther tr		Barbara Stewart - daughter 16 Winding Woods 20a. Method of Disposition 20b. Place of Disposition (Name of									
Baltimore, Maryland 21215-0036	ge 1 ant of F		20a. Method of Disposition 1 Burial 2 □ Cremation 3 [C	emetery, cren	natory or other pla		Date		•	
Ē	t. Pa tme tant tant jury		4 Donation 5 Other (Specify) Parkwood Cemetery 5/20/11								ltimore	
Ba	perm Depa Impo any i	22. Name and Address of Facility GJ Gonce Funeral 169 Riviera Drive Pasadena, MD										Home, PA 21122
		Н	23a. Part 1. Enter the disease, or con	nplications that caused	the death						ila, m	Approximate
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	р #	nin	if any, leading to immediate Due to (or as a consequence of):									
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Box 68760	requires that the death certificate been signed by the attending physishould be detached for use as the be	Physician/Medic		d								
99	certifinding use a	<u> </u>	IF FEMALE: 23b. Was decedent pregpent	23c. If yes, outcome] F.A i				23d. Date of del	ivery
30	death e atte	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at		leath 5 L	Ectopic pregnan Other (specify)				Month	Day Year
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σ,	es tha igned be de	þ	Part II. Other significant conditions	contributing to death b	ut not resi	uiting in the u	ngeriying cause g	iven in Part I.				the cause of death?
rds	equire	Completed by										
ပ္တ	law r has b le 2 sl	ď							24a. Was a		prior to death?	topsy findings available completion of cause of
m	r: The ficate r: pag		25. Was case referred to medical						1 Tyes	2 7 K		2 🗆 No
ſita	Physician: The law this certificate has ral director, page 2 :	o Be	examiner?	Hospital:	-1.00	ED/O	_ Oth	lace of Death (Chec		7		~)
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Division of Vital Records,	il or Attending P s after death. I Director: After t d in by the funera	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		ry - At ho	me, farm, stre	eet, factory, office		28f. Location (S City or Tow			al Route Number,
وَ	oital o urs af ral Di											le le
	Hospital 24 hours Funeral I eted filled	Medical	(Check 2 L Medical Exan		kamination	n and/or invest	igation, in my opin	ion, death occurred a	at the time, date a	nd place	e, and due to the o	cause(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. with a 44 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the London.	_	odi otto i i i i i i i i i i i i i i i i i	rse Practioner: To the			00.11					
			*Weleniee M	1) Attend	ing	Doct	7	D 216	84	6	05-1	8-2011
	10		30. Name and address of person who	completed cause of de	eath (Kem	23a) (Type, P	Print)	- // 04	000	2 /	RNA	MD 21/22
	10		30. Name and address of person who C-V. CYRIAC. 31. Data filed (Month, Day Year)	M.D. 8	02	1 Ki	TCHIA	i mo	PMST	101	2111	TU allag
	Stat Registra		31. Date filed (Month, Day, Year) NAY 1 9 2011	32. Registra	s Signat	arkal						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nancy F. Cortezi Physician/ Month Day М May 16. Medical 2011 5:50 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Keswick MultiCare Center Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea Dec 28.1917 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Months 93 213-14-0596 **Director** Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City, Town or Location within 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Director MD N/A 1XX Yes 2 ☐ No Baltimore 4 8 1 ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3939 Roland Avenue #708 U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Force Black, White, etc. ō ģ 1 Never Married 2 Married 1 Yes 2 XXIo Baltimore, Maryland 21215-0036 1 Yes 2 WNo Specify: "natural" 3√ Widowed 4 □ Divorced Specify. Completed White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Department of Health and Mental Hygene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Domenic Piccione Carmella Donato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Cortezi (Son) 119 Harbor Drive Cape Capaveral 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Temperatural 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/19/11 Baltimore, MD Holy Redeemer Cemetery 21. Signature of Funeral Service 22. Name and Address of Facility 3631 Falls Road I Burgee Henss-Seitz Funeral Home, Inc. Balto, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one on each line Immediate Cause (Final Physician/ disease or condition resulting in death) CANCE 4000 Knowe Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) Pregnant at time of death Day the 9 Unknown Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page After this certificate 2 N 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No Hospital Other: ဂ္ 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending Accident Investigation М within 24 hours after death

To the Funeral Director: A 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number

State Registrar

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B-14 MO 21211

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702 West you st

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Saluje Mo

31. Date filed (Month, Day,

MAY 1 9 2011

5/16/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May**18, Donna W. Cregger 7:00 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Rockville Montgomery 803 Carter Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Months Days Hours 64 December 12, 1946 Wash Trigton, D.C. 218-52-9338 Director Yrs Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location death with the Maryland must be notified at 10d. Inside City Limits Director Rockville Maryland | Montgomery 1 Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 803 Carter Road 20852 United States 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 🛭 No If Yes, Give filed within 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than County Schools Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha Business Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Patricia Barnard George W. Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra once. 803 Carter Road, Rockville, Maryland 20852 Danny D. Cregger/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Park Lawn 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 2011 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland Memorial 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville; Maryland 26850 Montgomery Avenue 21. Signature of Funeral Service License M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Metastatic Carcinoma of the Ovary Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 4 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? Yes 2 No Hospital or Attending Physician: The 1 🗆 Yes 2 🗆 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 🗆 Yes 2 🔀 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending after death. 1 🗌 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

Kahert H Huar

Robert H. Gerard, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

D0055522

1500 Forest Glen Road, Silver Spring, Maryland 20910

May 18, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^D2011 5:45 P M May 16, Jean Hughes Callahan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Montgomery Hospice Casey House Rockville 5. Social Security Number 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏻 F Months Days Hours 84 Yrs October 13, 1926 Washington, DC **Director** 216-22-1062 Usual Residence of Decedent 28a-f show notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🕱 No Maryland Ellicott City Howard 10e. Street and Number ò 10f. Zip Code 10g, Citizen of What Country? Medical Examiner must be with t 23a Funeral 21042 United States 5330 Dorsey Hall Drive items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes, 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. "natural", Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Own Home Homemaker Be permit. Page 1 and 2 should be file.
Department of Health and Mental HImportant: If item 27 is many injury or other 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Bessie Chaney Archibald Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3636 Wheat Miller Drive, Mt. Airy, Maryland 21771 Kathleen Basile / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 □ Cremation 3 □ Removal from State May 20, 2011 Silver Spring, Maryland Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home / Rockville, Inc. M01619 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Dementia Sequentially list conditions, Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit Cerebral Vascular Disease physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ned by the atten edetached for u in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 death? certificate Yes 2 X No 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 12 2 🗓 No Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) hours after death. Ineral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural work?
1 Yes 2 No 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month. Dav. Year) eu D37142 May 16, 2011

Registrar

DHMH 17 Rev 7/2009

State

1355 Piccard Drive #100, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registraris Signature

Geoffrey Coleman,

17 2011

31. Date filed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ -RROL 0245 PM 2011 Medical 4c. County of Death
Baltimore Co. 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Randallstown Northwest Hospital 8. Date of Birth 1 1/Mb/1/h4Pay,1/e9/3 9 9. Birthplace (State or Foreign Many Land Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months 1 🔀 M 2 🗆 F Hours Min. 71 Director 220-36-7938 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified Baltimore N/A MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21211 3939 Roland Ave. Apt203 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc ģ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 11th Grade College (1-4 or 5+) Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Florence unk John Carroll Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 931 Bethune Rd., Baltimore, MD 21225 Marsha Carroll(daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 D Burial 2X Cremation 3 D Removal from State on-site Crematory 05/19/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. S. natur of Funeral Service Licensee 276sephdren of Fabirown Jr. Funeral Home PA 21217 Baltimore, MD 2140 N. Fulton Ave., Art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Meta disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). Exam The law requires that the death certificate be executed burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? signed by the atte Day Pregnant at time of death 1 Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by cate has been sig page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide 4 hours after death uneral Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month. Dav. Year) 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DiPaula 11:15 PM -rank 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death University of Maryland Medical Center Baltimore N/A 8. Date of Birth Sep. 21, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Year)194<u>6</u> Days Min. 1 □**X**M 2 □ F Months Hours 218-46-8975 64 Maryland Director Usual Residence of Decedent 28a-f shov 10a. State 10h Counts 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location Director 1 ☐ Yes 2X No Catonsville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1909 Beverly Road 21228 United States within 72 hours after death with Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 No Navy

If Yes, Give Black, White, etc 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural", Specify White 3 Widowed 4 Divorced Completed d 2 should be filed within 72 hours alth and Mental Hygiene. 127 is marked other than "natural er traumatic event, the Medical E) er traumatic event, the Medical E) Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Trucking/Freight Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Leonard DiPaula Mary Ellen Ziegler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 1909 Beverly Road, Catonsville, MD 21228 Nancy DiPaula - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 5-20-2011 Baltimore, MD Loudon Park Cemetery ! Ronation 5 Other (Specify) Funeral Service Lien 22. Name and Address of Facility Ambrose Funeral Home, 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) cardiogenic Shock days Medical Due to (or as a consiguence of) **Examiner** oronaru artery Sequentially list conditions. Due to (or es a consequence of) Examine cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) jo in the past 12 months? Month Day Year Pregnant at time of death 2 No signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform After this certificate 1 ☐ Yes 2 ☐ No I ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) nin 24 hours after death. the Funeral Director: After this apleted filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation M 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1063737518 5/15/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Greene St. Baltimore, MD 21201 22 Sarah strars Signature 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 16, 2011 Frederick Charles Deisher, Sr. 7:00A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1233 Clearfield Circle Baltimore Lutherville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 □ F Hours **Director** 181-22-8427 83 Sept Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits 1 🗌 Yes 2 ី No Maryland Baltimore Lutherville 10e. Street and Number 10g. Citizen of What Country? Funeral 1233 Clearfield Circle USA Lutherville 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 🗌 Widowed 4 🗌 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Accountant Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alfred Frank Deisher Marv Bond Amy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1233 Clearfield Circle, Lutherville, MD 21093 Frances P. Deisher/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 5/19/11 🛚 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Domation 5 Other (Specify Dulaney Valley Memorial Gardens Timonium, Maryland 22. Name and Address of Facility Clar Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 ¥ 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, that ca Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (c Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

To the Funeral Director: After this certificate has been signed by the attending physician and the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 K Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: ည 1 ☐ Yes 2 🔀 No 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deatl 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a 29d. Date signed (Month, Day, Year) May 19, 2011

State Registrar DHMH 17 Rev 7/2009 Schilling Road, Hunt Valley, Maryland

21031

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Back

Mark A. Lamos, MD

31. Date filed (Month, Day, Year)

MAY 1 9 2011

			State of M	laryland / De		lealth and	-	2011	16020	
			Registrar 1. Decedent's Name (First, Middle, Last)		- Incate of E	Calli	2. Date of De	Reg. No.	3. Time of Death	
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			221 Lake Road 5. Social Security Number 16. Sex 17. Ag		Pasad		T	Anne Ar		
	Funeral Director		218 26 3121 ^{1□M2} F	8 1 Yrs.) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 3/21		rthplace (State or Foreign ountry)	
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	the la or 2 be no		10e. Street and Number		10f. Zip Code			10g. Citizen of What C	ountry?	
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036	s afte ral", c Exam		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 1 ☐ Yes (3 🔀 Widowed 4 ☐ Divorced Year or Dates.	No	1 ☐ Yes 2 🔀 No	Specify:		Specify: [hite	
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Baltimore,	if. Page intment o intant; If injury or		4 ☐ Donation 5 ☐ Other (Specify)	Glen Ha	aven Mem	Pk 5/1	6/11	Glen Bur	nie, MD	
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Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completed filled in by the funeral director,		27. Manner of Dea h Natural 5 Pending Accident Investigation	ry 28b. Time of injury	work?	at		ow injury occurred		
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	5		30. Name and address of person who completed cause of de SRIDITAR ATLURI : 731	o Ritchie	Print) Highway	; Suite 81	o Gle	n Burnie	MD 21061	
	Stat Registra	_	32. Registra NAY 1 9 2011	Signature factor			,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ma Vonth Physician/ 201^Y1ar Robert. 7:00 A M Glenn Ewart Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 807 Hayden Way Bel Air 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year) Days Hours Min 1 XM 2 D F 173-18-3271 Director 91 Yrs. Usual Residence of Decedent show 10b. County event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 🏝 Yes 2 🗆 No Maryland Harford Bel Air ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 Funeral items 23a 807 Hayden Way 21014 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ō 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", Specify: White 3℃ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hyglene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Coal Miner Underground Mining Be 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William (nmn) Ewart Minnie (nmn) Barklev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl tment of Health a tant: If item 27 l Glenn Ewart Jr. / Son 807 Hayden Way, Bel Air, Maryland 21014 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) ò injury o 4 ☐ Donation 5 ☐ Other (Specify) 5-21-11 Greendale Cemetery Masontown, PA Signature of Funeral Service 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ARTERIOSCLERUTIC CARRYOVASCUL et and Death Physician Medical resulting in death) bue to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or) for use as the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day Year 4 ☐ Pregnant 9 ☐ Unknown the detached 9 Unknown P.O. ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by within 24 hours after death.

To the Funeral Director: After this certificate has been signe completed filled in by the funeral director, page 2 should be o the Hospital or Attending Physician; The law requires DEMENTIA Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital Other: 5 Residence 6 Other (Specify) မ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print NOMTH

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	,		e of Maryland / De	Indelible Ink. Ensure A partment of Health and N ertificate of Death		ne 2011	16040		
Physicia Medic Examin	cal	Decedent's Name (First, Middle, Last) Roland Luther E 4a. Facility Name (if not institution, give street and	number)	4b. City, Town, or Location of Death Westminster	2. Date of Death Month May 18	Day Year 2011 4c. County of Death	3. Time of Death 10:08 AM		
Funeral Director		Carroll Hospice Do	8. Date of Birth (Month, Day, Yea, 4-5-1924	Carroll 9. Birthp Count MD	olace (State or Foreign try)				
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I and 2 shou f Health and tem 27 is m other traum		19a. Informant's Name/Relationship (Type, Print) Evie L. Hathaway-d 20a. Method of Disposition	aughter 24		l.,Dentor	•	29		
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× sm		30. Name and address of person who completed of Flavio Knots 555 Suff	ause of death (Item 23a) (Type,		21157	-14	[[
Stat Registra		31. Date filed (Month, Day, Year) NAY 1 9 2011	2. Registrar's Signature	all .			-		

			Please 7	Type or Pri AMEND TT State of M	nt in Bl EM#201 aryland	ack in	delible In H.#23a, T artment of F	k. Ensure or I, II per Health and	All Copie PHYS, G9 Mental Hy	S Are	Legible	1,WS
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	Physicia Medic		Decedent's Name (First, Middle, Last) Tara			Feing	gold		2. Date of De Month	eath Da	2011	3. Time of Death 1 2, 55 AM
	Examin	er	4a, Facility Name (if not institution, give st St JOSEON MC	dical	Cent	ER	TOUS	r Location of Death		_ [County of Dea	more
	Funeral Director		5. Social Security Number 6. Sex 215-90-8131] м 2 [X F	e (In yrs. last 33	birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bi	$\stackrel{\scriptscriptstyle{ ext{rth}}}{1},\stackrel{\scriptscriptstyle{Year}}{1}$.977 9. Bir	thplace (State or Foreign untry) laryland
	how how	۱	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Loc	eation					10d. Inside City Limits
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	with the N 23a or 2 st be no	Funeral Director	10e. Street and Number 1223 Cowpens Avent				10f. Zip Code	 286		_	tizen of What Co	ountry?
336	ge 1 and 2 should be filed within 72 hours after death with the Maryland tr of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	b		2. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		- 1		lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No o Rican, etc.)	-	14. Race - Ame Black, Whit Specify: Wh	e, etc.
2-0	hours "natur dical l	plete	15. Decedent's Edu (Specify only highest grad	cation		16a. Deced	lent's Usual Occup	nation during most of wor	kina	16b. H	Kind of Business	
21215-0036	within 72 giene. ier than '	Completed	Elementary/Seconday (0-12)	College (1-4 or 5		life. DO	O NOT use retired)		Ü	Nı	ursing	
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aryle	ould b		Robert 19a. Informant's Name/Relationship (Typ)	G. e. Print)	Mur		a Address (Street	Barba and Number or Ru		L. er City o	Swens	
2	and 2 sh Health aı tem 27 is other trau		Barbara L. Swenson				Cowpens				aryland	21286
Baltimore,	Page 1 an nent of He ant: If iten ury or oth		20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		cem	netery, cren	sition (Name of natory or other place Mem. Parl		Date -ÎÎ 9-2011		ocation - City of	Town, State Maryland
Balti	permit. Page Department of Important: It any injury or		21. Signature of Orienal Service Licenses	an		22		ss of Facility Ru	ick Tows			Home, Inc.
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one Immediate Cause (Final	1	the death. [Do not ente	er the mode of dyin	ng, such as cardiad	or respiratory a	arrest,		Approximate Interval Between Onset and Death
0	Physician/ Medical		disease or condition resulting in death)	Due to (or as	nonu	0					_	Days
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09,	cate be ex physician s the buria											
. Box 68760	ath certifi attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	eath 3	Ectopic pregnand Other (specify)	су			23d. Date of de Month	elivery Day Year
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ia F	i ician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?					lace of Death (Che		, Z L I	10	
of Vital	Physic this ce al dire	၉	1 Yes 2 □ No H				nt 3 X DOA Oth	4 L Nursing I			6 ☐ Other (Spe	cify)
o uo	ending Physician: T aath. or: After this certifica he funeral director, p	Certificate:	1 Natural 5 Pending 2 Accident Investigation	28a. Date of inju (Month, Da	y, Year)	Bb. Time of injury	work		28d. Describe	how inju	ry occurred	
Division	al or Attendi s after death Il Director: A ed in by the f		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulging, etc		e, farm, stre	eet, factory, office		28f. Location City or To			ural Route Number,
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical		cian: To the best of er: On the basis of e Practioner: To the	xamination a	nd/or invest	igation, in my opini	on, death occurred	at the time, date	and plac	e, and due to the	cause(s) and manner stated
_	To the I within 2 To the I comple	-	29b. Signature and title of certifier				29c. Licens			29d. Da	ate signed (Mon	th, Day, Year)
					MO	3-1 (77	0004	20445		5	116	11
1 J			30. Name and address of person who con	mpleted cause of d	eath (Item 23	sa) (Type, F	rint)	Tows	m.m	0 :	21204	f
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	المعا						

16042 State of Maryland / Department of Health and Mental Hygiene U For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Joseph Fiala, Jr. 9:00 PM 2011 14. May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 9. Birthplace (State or Foreign Country) Havre de Grace, MD 8. Date of Birth (Month, Day, Year) Aug. 24,1959 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2 □ F Days 213-68-065 1 51 Director Usual Residence of Deceden ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Funeral Director Harford Edgewood 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 210 40 837 Kingston Court United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō Completed by 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. White Specify: "natural", 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Maintenance Elementary/Seconday (0-12) Public School Employee other traumatic event, the 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Agnes Liebscher Fred Joseph Fiala 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 837 Kingston Court Edgewood, MD 21040 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health an Important: If item 27 is 1 Vickie Fiala/Wife 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 22, Evans Funeral Chapel – Bel Air 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 Donation 5 Other (Specify) 2011 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services
3 Newport Drive Forest Hill, Maryland 2000 Signature of Funeral Service Licensee 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Ph_sician/ mracerebral hemorrhage Medical re ulting in death) Due to (or as a consequence of): Examiner Syndrone MENCIM ant kidi Antiphospholipid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last nknum attending physician and for use as the burial-trar Physician/Medical 6 days Cardiac arrest 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year been signed by the s should be detached Hospital or Attending Physician: The law requires that the 24 hours after death.
Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 myocardial 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 █ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? disease end stage rendl 24a Was an performed atrial fiballation 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work 1 Yes 2 No 2 Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00065421 MO May, 14, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chesapeake Drive, Bel Ar Manyand 21014 500 Tistle, UPPER 31. Date filed (Month, Day, Year) 72. Registrar's Signature MAY 1 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 3,528te of Maryland 15 essytment of Health and Mental Hygiene 1 - For A State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Unknown M 201 /Medical 4a. Facility Name (If not institution, give street and nul 4c. County of Deat 4b. City, Town, or Location of Death Examiner Baltimore 3 Woodbine 9. Birthplace (State or Foreign Country)
Carolina If Under 1 Year I If Under 24 Hrs. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Days 1 M 2 □ F Months Hours 58-064 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Medical Examinar in ust be notified at 1 res 2 No Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Woodbine Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cubari, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. ☐Yes 2 Yes, Give 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No Specify 3 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired), Elementary/Secondary (0-12) College (1-4or 5+) onstruc 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ferguson James 19b. Mailing Address (Street and Number or Rural Route Number, 19a. Informant's Name/Relationship (Type. Print) City or Town, State, Zip Code) Manyland 70' te rauson Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State mit (eneter 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service ar evi ar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ENERGIOVASCULAN Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner 90P915 Sequentially list conditions Examiner Dua to (or as a ed (secuence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of) attending physician Records, P.O. Box 68760 Physician/Medical as the t IF FEMALE: for use yes, outcome of pregnancy
Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ TZUNA INSUFICIONUM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should DIABOTE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 🗆 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director; filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 13,2011 MAY leted cause of death (Item 23a) (Type, Print) 30. Name and addless of person who com

State Registrar S1. Date filed (Month, Day, Year)

MAY 1 0 201

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CATONSVIllE

's Signature

32. Registral

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ MAY 18, 2011 6:30 A JEANNE ELLEN ARMSTRONG FOSTER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, une 21 Year 1 □ M 2 🖾 F Hours Min. **Director** <u>June</u> Pennsylvania 185-24-7245 Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f sho. ral", or items 23a or 28a-f sho Examiner must be notified at **Funeral Director** 1 X Yes 2 ☐ No Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 48 West Gordon St. 21014 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced Completed White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home <u>Homemaker</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Sickler Ethel Lavina Albert Ledmon Armstrong item 27 is marke other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 i 11 West Park Place, Middletown, DE 19709 Jeffrey W. Foster / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Zion U.M.C. Cem. Bel Air, Maryland 5-21-11 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, I Funeral Service Licensee Signature 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COPD Physician/ disease or condition resulting in death) **Medical** Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last the burialphysician Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown 9 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed to should be deta 23e. Did tobacco use contribute to the cause of death? by Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Records, CHF Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Be Other: Hospital: 1 Yes 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural Accident 5 Pending in 24 hours after deam, the Funeral Director: Aft 1 🗌 Yes Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29c. License number 29b. Signature and title of certifie 032275 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

DAVID DUNN
1. Date filed (Month, Day, Year)

192011

21014

BEL AIR, MD.

615 W. MACPHAIL ROAD

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mayonth 17, Physician/ Melvin Goetze, Jr. 2011 9:59 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson 8. Date of Birth NOV 8, Year 916 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 ▼M 2 □ F Hours 212-07-3518 94 Maryland **Director** Jsual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Baltimore 1 ☐ Yes 2 No Towson 12/2011 1020AM 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1055 W. Joppa Road U.S.A. Apt. 327 21204 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ "natural", or 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify. 3 Widowed 4 Divorced Specify: White Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event "... (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Chairman of the Board Goetze Candy Company yrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Melvin Goetze, Bernadine Traeg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spaulding A. Goetze, Sr. / Son 3900 East Monument Street Baltimore, Md. 21205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Druid Ridge Cemetery 5/20/2011 Pikesville, Maryland 4 Donation 5 Other (Specify) 21. Signatur Fune Sovice Livensee 1050 York Raod 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part 1. Enter the diseas Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final DEMOU Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialphysician the burial Physician/Medical P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death 2 No signed by the a d be detached f 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available page 2 s prior to completion of cause of autopsy UROLIE Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical exampler?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Yea 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d Describe how injury occurred 1010 1 Natural
2 Accident 5 Pending work? 1244 accelent 2 **I**No May 16,2011 Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Pry e of Injury - At home, farm, street, factory, office b. Iding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of the knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item/23a) (Type, Print) 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Item 25 State of Maryland 5 Penartment of Health and Mental Hygiene Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month Martha L. Holley AM 6:29 No 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinci Hospital of Paltimore Baltimore City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours Mir (Month Day Year) 1 M 2 X F 78 Yrs Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore 1 🗆 Yes 2 🛛 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21707 USA 3408 Fairview Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Je filed wાહ. વ્ય Hygiene. ેલા than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper Private Home 12th grade Be 17. Father's Name (Prst, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ernest Moore, James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danis W. Holley 20 McDonogh Road Kandallstown MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 14/2011 Merry Hill, NC 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral Services 8728 Liberty Load Randallstewn MID 21133 23a. Part 1. Entet the Usease, or complications that caused the death. Do not enter the mode of dying, as a cardiac or respiratory arrest, shock, or he at failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Physician/ Intracerebral hemorrha disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions Examiner if any, leading to immediate cause Enter Undarlyin Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery in the past 12 month 1 Yes 2 No Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by previous stroke, hypertonsion, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an spiral cond stensis, multip 2 No 1 ☐ Yes 2 ☑ 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural injury work? 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title o 29d, Date signed (Month, Day, Year) Res -000 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Surgit Saha Hospital of Baltimore Sinei M.P. 31. Date filed (Month, Day, Year, Registrar's Signat State barks 19 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 201 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** 9. Birthplac If Under 1 Year | If Under 24 Hrs. e (State or Foreign Age (Ingrs. last birthday) **Funeral** Days Hours Min Director Usual Residence of Decedent City Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Tes 2 ☐ No Director Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: Specify Completed by 3 Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use lettred) (Specify only highest grade completed) Elementary/8 condary (0-12) College (1-4 or 5+) Be Baltimore, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Chter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and d for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No P.O. by the Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, page 2 should be 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate has 2 No 1 Yes 1 Tyes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 XNo Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) ٩ completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation Injury 1 X Natural 1 🗌 Yes Accident 3 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 2011 RES - 000 17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Snivatsan 600 North Wolfe St, Baltimore, MD, 21287 havan

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Registrar

31. Date filed (Month, Day, Year)

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3. Registrar's Signarare

the attending physicien end ched for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Director: After

with the Marylend

filed withIn 72 hours after death

Baltimore, Maryland 21215-0036

completely filled in by the funeral within 24 hours a

> State Registrar

Medicai

29a. Certifier

29b. Signature and title of certifier

MAY 1 9 2011

Cowalen 31. Date filed (Month, Day, Year)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed, (Month, Day, Year)

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** 11:00 A^M May 10, Hurwitz 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ring House Rockville Montgomery 8. Date of Birth (Month, Day, Year March 15, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours 1 □ M 2 🕶 F 1924 New York Director 073-18-5075 87 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Pages 1 and 2 should be filled within 72 hours after death with the Maryla nent of Health and Mantal Hyglene.
The strain of the strain and strain and the strain or items 23a or 28a-1 show and it if item 27 is marked other than "natural", or items 23a or 28a-1 show my or other traumatic event, it is marked Expresser mast be notified as uny or other traumatic event, its marked Expresser. 1 ☐ Yes 2 X No Director Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1801 E. Jefferson Street #328 20852 U.S.A. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2X No Specify. Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Sonenshine Esther Relf 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Hurwitz (Son) 11207 Clara Barton Dr., Fairfax Station, VA 22039 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Alexandria, VA 4□ Donation \$□ Other (Specify) Metropolitan Crematory 5/12/2011 22. Name and Address of Facility
All Veterans Cremation Service
3200 Wadsworth Blvd., Wheat Ridge, CO 80033 21. Sign ture of Fur eral Service Licensee uns 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Stage Renal Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 1 ☐ Yes 2 ☒ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

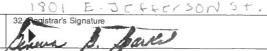
To the Funeral Director: After this certifics completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier Unu Timelin CRNP R172412

101

State Registrar Alyson Timin 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



ROCKVILIT, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 10:00^A M Kristina Hryczaniuk May 5 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Future Care Chesapeake Arnold Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 1 F Director 577-48-3421 85 5/30/1925 Germany Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2X No MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4981 Perthshire Path 21061 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 N Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Meat Processor Meat Processing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Ganser 2 Klara Hintermayr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Serfass 4981 Perthshire Path, Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any Injury or o 1 ₺ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Dther (Specify) 5/21/2011 Louisa Co., VA Jude Cem. 21. Signature of Funer Service Licensee 22. Name and Address of Facility Preddy Funeral Home \rightarrow 301 N. Main St., Gordonsville, VA 22942 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) end stage /Medical Due to (or as a conse un ce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Physician/Medical nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month Year 5 Other (specify) ed by the a 1 ☐ Yes 2 ☑No P.0. 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Unursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation 2 🗌 No 1 TYes 2 Accident nin 24 hours after deat the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within To the 29b. Storature and title of certifier 050725 eterans Huy M. Mersulle MD 2/108 who completed cause of death (Item 23a), (Type, Print

State Registrar

OV

31. Date filed (Month. Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Month loan Herschler 13 1624 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery 8. Date of Birth (Month, Day, Ye March 14, Social Security Number 9. Birthplace (State or Foreign Country) Pennsylvania 6. Sex If Under 1 Year If Under 24 Hrs Funeral Days 1 M 2 X F Director 202-32-0843 70 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2 No Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13717 Drake Drive 20853 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 ₺ Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Je filed with... خا Hygiene. تد than "p (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 3 Law Firm Legal Secretary permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Schilpp Helen Sass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey M. Herschler/ Son 3301 Frow Avenue, Coconut Grove, Florida 33133 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) Montgomery Crematorium Inc. 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 18,2011 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Furteral Service Licensee 23a. Part 1. Enter the dis or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Ylhmid Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence or). sician and burial-transit Due to (or as a consequence of): resulting in death) Last physician s the burial Completed by Physician/Medical Box 68760 attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav signed by the a d be detached f 1 ☐ Yes 2 № 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did toba use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown s been si should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed' death? of Vital 25. Was case referred to predica 26. Place of Death (Check only one) examiner? Other: 1 \square Yes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this a completed filled in by the funeral dil 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Division ☐ Accident ☐ Suicide Investigation 6 ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) s of person who completed cause of death (Item 23a) (Type, Print) 18/01 31. Date filed (Month, Day, Year) 32. Registrar's Signature State barre Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Day Ursula Ingrid Heine Medical May 2011 10:58 AM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carriage Hill Bethesda Montgomery Bethesda . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8 Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 1926 1 🗆 M 2 🛛 F Months Days Hours **Director** 237-66-9219 85 Germany Usual Residence of Decedent 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits or 28a-f 1 Yes 2X No Maryland Silver Spring Montgomery the 10f. Zip Code 10g. Citizen of What Country? pe by Funeral 23a 3100 N. Leisure World Blvd. #125 20906 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. "natural", or iter edical Examiner 14. Race - American Indian. Armed Forces? Black, White, etc. and 2 should be filed within 72 hours after of Health and Mental Hygiene.

tem 27 is marked other than "natural", or ther traumatic event, the Medical Examir 1 X Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Medical Researcher Medical School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frida Alice Gunhold Georg Gustave Heine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 West Middle Lane, Rockville, Maryland 20850 David R. Podolsky/Attorney Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. May 19, 2011 | Bethesda, Maryland Signature of Funeral Service Lice see Röbert A. Arumphirey Funeral Home/Bethesda-Chevy Chase, Inc. > The Don M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ 3 Months disease or condition resulting in death) End Stage Renal Disease Medical Due to (or as a consequence of) Examiner Diabetes Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or linjury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Year Day signed by the ar P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed <u>Congestive Heart Failure</u> 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 X No 1 Yes 2 No Division of Vital filled in by the funeral director, or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Certificate: To 1 ☐ Yes 2 🗓 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural 5 Pending injury s after death. work?
1 Yes 2 No Accident Investigation M Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death unclaimed at the time, date and place, and due to the cause(s) and manner as stated. (Check

18

homas

Thomas Masterson,

Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist

Registrar DHMH 17 Rev 7/2009 29c. License number

D50534

M.D. 6858 Old Dominion Drive, Suite 104, McLean, Virginia 22101

29d. Date signed (Month, Day, Year)

May 16, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 Paul J. Heying Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. or Location of Death 4c. County of Death Examiner ALTIMORE HOSPITAL HENES Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral July 24 Year) 1938 Mary Land Months 216-34-0514 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director Md. Anne Arundel Co. Linthicum 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 402 Darlene Avenue 21090 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. Elementary/Seconday (0-12) College (1-4 or 5+) Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ August F. Heying Marie Emma Kadan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Heying, daughter 3235 Callerton Rd. Clermont, Florida 34714 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🗹 Burial 2 🗆 Cremation 3 🗆 Removal from State Meadowridge Memorial 5/23/11 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Hgwy. Balto. Md. 21225 23a. art 1. Enter the diseas of complications that caused shock, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ EPSIS disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ISCHEMIC CARDIOMYOPATHY Records, 1 Yes 2 No 3 Probably 4 Unknown FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of autopsy PERIPHERAL VASCULAR DISEARA performe death? 21 No Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 Ves 2 No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital of 24 hours a Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check o the lithin 2 29b. Signature and title of certifier D0040012 ess of person who completed cause of death (Item 23a) (Type, Print) LRD, SUITE 204, BALTMORE, MD 21228

State

Registrar

YOULTON

9 2011

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Amend 23a, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAPTY 5.53AM 30 11 Thomas A. Hines, Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON MEDICAL CEN BURNIE ANNE ,LEM If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months **X**X M 2 □ F Days Min. Hours 1/2/19/11/942 216-40-0952 Country) 68 Director Yrs. MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f MD 1 Yes 2 XXIo Anne Arundel Severn 10e. Street and Number 9 10f. Zip Code items 23a or ner must be r 10g. Citizen of What Country? by Funeral 8135 Windmill Court 21144 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. er than "natural", or iter the Medical Examiner Armed Forces? ▼▼ Yes 2 No If Yes, Give 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. and Mental Hygiene. is marked other than "natural", Completed 3 Widowed 4 Divorced White Year or Dates KINGS, THOMASA 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Truck Driver Transportation traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Thomas C Hines Jean Lehnert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Mrs. Faye Hines / Wife 8135 Windmill Court Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem Park 5/17/2011 Glen Burnie, MD Signature 22. Name and Address of Facility Singleton Funeral & Cremation neral Se M01220 Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or emplications that caused shock, or heart failure. List only one cause on each line emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ AILUEE End stage renal disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to or as a conse quence of -transit and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day Year ed by the Unknown 9 Unknown P.O. s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 🗷 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.
Funeral Director: After thieted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | 3 | within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) May 12. 2011 LABA completed cause of death (Item 23a) (Type, Print) Gleu Burnie 301 Hospital 31. Date filed (Month, Qay 32. Regi State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 74cg7 AM (Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northwest Hospice Baltimore Randallstown If Under Year If Under 24 Hrs. Security Numbe . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Hours 90 **Director** <u> 217-22-306</u> Usual Residence of Decedent Show 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be i Funeral 3303 Leighton Avenue 21215 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. African 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates Specify: American 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade NAMachine operator Western Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Minnie Coleman Nathan Coleman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $~^212$ 15 19a. Informant's Name/Relationship (Type, Print) 5603 Bland Avenue Baltimore, Maryland Louis M. Hamlet-Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 05-20-11 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Owings Mills, MD 22. Name and Address of Facility Wylie Funeral Home P.A. Signature of Funeral S Street Baltimore, MD 21217 638 Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine cause. Enter Underlying Due to for as a consequence of Cause (Disease or linjury and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown the detached Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 s autopsy 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Doth Certificate: 28b. Time of 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and titl completed cause of death (Item 23a)

State

Registrar

MAY 1 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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36	Physici		1. Decedent's Name (First, Middle, Last)	HUNT						te of Death	Day 18	rear//	3. Time of Di	eath M							
1	/Medio Examir		4a. Facility Name (If not institution, give s	treet and number	.)		4b. City, Town, c				4c. County of	Death	PAP								
	Funeral Director		5. Social Security Number 6. Sex		ge (In yrs. ia 78	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Mo	te of Birth onth, Day, Yes 21-193	ar)	9. Birthpl Coun	ace (State or F try) MD	Foreign							
nore, Maryland 21215-0036 ges 1 and 2 should be tiled within 72 hours after death with the Maryland to the Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28e-1 show or other traumatic event, the Medical Examinar most by notified at	Funeral Director	MD HARFORD 10e. Street and Number 400 THOMAS RUN RD. 11. Marital Status	• 10			BEL AIR 10f. Zip Code 2101	BEL AIR			10d. Inside City Limits 1 □ Yes 2 ☒No 10g. Citizen of What Country? U • S • A • 14. Race - American Indian, Black, White, etc.											
21215-0036	d within 72 hours aft giene or then "naturel", or the Medical Execut	Completed by F	1 Never Married 2 Married 3 XWidowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	If Yes, Give Year or Dates cation		16a. Deced (Give life.	1 ☐ Yes 2 🔀 No dent's Usual Occul kind of work done DO NOT use retire PEACHER	pation during most of	of working		Specify: Kind of Bus	iness/Ind	ACK								
Maryland	should be filed vand Mental Hygie smarked other i umatic event, the	To Be C	17. Father's Name (First, Middle, Last) WILLIAM A. BANKS						s Name (First, KEANNA		len Sumame,)									
Baltimore, Mar	permit. Pages 1 and 2 sh Department of Health and Important: if itam 27 is m any injury or other traum once.		19a. Informant's Name/Relationship (Typ. WALTER LARRY BANKS/ 20a. Method of Disposition 1☑ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	SON	9	604 ace of Dispo	og Address (Street Corsair sition (Name of matory or other pla Mem. Gard	Ct. Sk	yville Date	, MD 2		ity or To	wn, State								
Balti	permit. I Departm Importal any inju		21. Signature of Funeral Service License	е	пат	W22	Name and Addre LILiam C. LS. PHII	ess of Facility Brown	Comm.	Funer	al Hom	е-На	rford l	P.A.							
\$8760,	Physician /Medical Examiner sthe purial-transit	Jical Examiner	cal	cal	ca	ical	ical	ical	ical	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or rinjury that initiated events resulting in death) Last d.	Due to (or a	line. SBS s a consequ HYPE s a consequ	ence of): KIEN ence of):	HEHRT						Approximate Interval Betwee Onset and De	
P.O. Box 6	the death certific y the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Mo 9 ☐ Unknown	3c. If yes, outcom 1 Live birth 4 Pregnant : 9 Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify) _	у			23d. Date Mont		ny Day Ye	ar							
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions conf							3e. Did tobacc	_		ie cause of dea ably 4 ⊟Un								
Il Records,	i cian : The law re certificete hes bec rector, page 2 sho	Completed	POLY & YSTIC	KIDN	by D	19EA	15E			ta. Was an autopsy performed	? de	or to cor	psy findings av npletion of cau 2 No	/ailable							
Division of Vital	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificete hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpat 28a. Date of Inj (Month, D	ury	ER/Outpatier 28b. Time of Injury	28c. Inju Wo	ner: 4 ☐ Nurs					9								
Divis	ital or Atturs after de rai Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined		njury - At hor atc. (Specify)		eet, factory, office			cation (Street ty or Town, St		or Rura	l Route Numbe	97,							
3	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examinons) 29b. Signature and title of certifier	and manner s	of examinati stated.	ion and/or in	vestigation, in my o	opinion, death	occurred at th	he time, date	and place, ar Date signed	nd due to	the cause(s)								
-	Su)		30. Name and address of person who cor	mpleted cause of	death (Item	23а) (Туре,		uren	DA	ne s	-21	AIR,	MP 24	614							
	Sta Registr		31. Date filed (Month, Day, Year) MAY 16, 2011	32. Regis	trar's Signati	ure								-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8state of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death May 17, Day 2011 Physician/ 7:01 A M Haka1a Kee₁y Elaine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 450 University Drive Severn If Under 24 Hrs 8. Dayoof Birth 7 (1997) Day Year 7 / 14 / 2004 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Davs Hours Min. Country) Maryland 1 🗆 M 2 🗶 F 220-69-6358 6 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1 Yes 2 No Severn Anne Arundel MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A. 21144 450 University Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, i "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Asian Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) N/ADependent Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F is marked of permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Eve C Huffman Rvan E. Hakala 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
450 University Drive Severn, MD 21144 19a. Informant's Name/Relationship (Type, Print) 450 University Drive Ms. Eve C Hakala / Mother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Glen Burnie, MD 5/18/2011 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ P0515 nue disease or condition resulting in death) Medical Examiner 2 week Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying Cause (Disease or iinjury that initiated events resulting in death) Last Examin -transit and Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day 5 Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No Division of Vital Records, 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number SM

Registrar DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:45 AM Fantroy Johnson Mav Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Refreshing Springs Nursing Home PG New Carrolton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) 11/11/1917 1 M 2 F Hours Min. 93 Director 579-16-3092 Washington, DC Usual Residence of Decedent f show 10a. State 10b. County items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director New Carrolton 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 6504 Adrian Street 20784 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black White etc. should be filed within 72 hours after d and Mental Hygiene. is marked other than "natural", or i \$ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black Completed 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Custodian Supervisor Federal Government 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grace Warner Robert Fantroy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20746 6405 Juanita Court; Suitland, Maryland 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is Warren Johnson-Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or HarmonyMem. Pk. 05/18/2011 Landover, Maryland 21. Signat of Funeral Service Licensee 22. Name and Address of FacilityFreeman Funeral Services 4594 Beech Road; Temple Hills, MD Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, singled or hear failure. List only one cause on each line. 23a. Part 1. Enter the disease, or Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cormary disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner theroscleroti Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 9 Unknown 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an his certificate hildirector, page To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director; I Vita 25. Was case referred to medical 26. Place of Death Check only one) Be examiner? Other: 2 No ဂ္ဂ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Division of 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural 2 🗌 No Accident
Suicide 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) VIN M. NAING MD MO 036623 5-16-11 Name and address of person who 160 Varnum

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edward Turner James 08P M MAY 2011 12 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER BALTIMORE TOWSON Social Security Number Funeral 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, M 2 🗆 F Days Months Hours Min. **Director** 215-34-1272 74 MD Feb. Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Baltimore Cockeysville 23a o. t be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9601 Labrador Lane 21030 USA ntal Hygiene. ed other than "natural", or items event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☐XNo Specify Completed 3 🗌 Widowed 4 🗌 Divorced Specify: white Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Posta1 Elementary/Seconday (0-12) College (1-4 or 5+) USPS n/a Postal Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Vivian Turner James Edna Evelyn Stubbins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth A. James/wife 9601 Labrador Lane, Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State 4 Denation 5 Other (Specify) Atlantic Crematory 5/19/11 Glen Burnie, MD 21. Igna Forgun ra se re Lichilsee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart railure. List only one cause on each line. Approximate shock, or heart/failu Immediate Cause Final Onset and Death Physician/ MULTIPLE SYSTEM ORGAN FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** RUPTURED ABDOMINAL AORTIC ANEURYSM Securately list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) sician and burial-trans resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be seen a hours after death.
Funeral Director: After this certificate has been signed by the attending physicis. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day signed by the a Yes 2 No 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð SEVERE LACTIC ACIDOSIS Division of Vital Records, cate has been signated bage 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed RESPIRATORY FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 2 No ၉ 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier 🛮 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 2 29d. Date signed (Month, Day, Year) D24034 1054 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMOTHY LOW M.D. 7601 OSLER DRIVE TOWSON, MD 21204 31. Date filed (Month, Day, Year, 32. Registrar's Signature State MAY 19 2011

Registrar

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ Wright K1emm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** GOOD SAMARITAN BALTIMORE HOSPITAL If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 7. Age (In vrs. last birthday 1 🗆 M 2 🕱 F Hours Director 84 181-20-1195 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code Funeral 21030 8 Gibbons Blvd. , or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status "natural", or iter Completed by 1 Never Married 2 Married Yes 2 X No 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) NOW 12 n/a Bank Representative other traumatic event, Be 17. Father's Name (First, Middle, Last) ၉ Wright Agnes George permit. Page 1 and 2 shoul Department of Health and Important: If item 27 is m any injury or other traum: 19a. Informant's Name/Relationship (Type, Print) Jennifer Mona O'Hara/Daughter 10 Gibbons Blvd., Cockeysville, MD EMM Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Donation 5 Other (Specify) **Atlantic Crematory** 5/17/11 Si Fin ar givice Lic Bryan W. Clary 23a. Part 1 nter ne disease, or complications nat c shock, or he it failure. List only one cause on each sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediat Ca (Final disease o dition resulting in death) NEUMONTA Physician/ Medical Examiner YELOMA Sequentially list conditions, Examine if any, leading to inmediate cause. Enter Underlying Cause (Disease or linjury END STAG attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death signed by the a a 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by HYPERTENSION Records, COROHARY ARTERY DISEASE To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 sl **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) B B examiner? Hospital: မြ 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work? 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. з 🗆 29b. Signature and title of certifie RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAM RAVEN BLVD BALTLMORE 31. Date filed (Month, Day, Year) State MAY 1 9 2011

State of Maryland / Department of Health and Mental Hygiene Reg. No 2. Date of Death 3. Time of Death Month 6 201 4c. County of Death n/a g. Birthplace (State or Foreign 8. Date of Birth Month, Day, Year) Aug 26, 1926 Pennsylvania 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify. White 16b. Kind of Business Industry Banking 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Glen Burnie, Maryland 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 11512011 BELBASE, MD

Registrar DHMH 17 Rev 7/2009 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Doris Elizabeth Lawrence May AM 201: Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 304 Washburn Avenue Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year June 27 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours Director 217-18-5805 91 1919 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland the Medical Examiner must be notified at Director Md. 1 Yes 2 No Baltimore 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 304 Washburn Ave. 21225 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) her own home 10 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Schmidtmann Adams Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Anderson, daughter Washburn Ave. Baltimore, Md. 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1
Burial 2 Cremation 3 Removal from State Bavview Crematorv 4 Donation 5 Other (Specify) 5/16/11 Balto, Md 22. Name and Address of FacilityGonce Funeral Service P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Hgwy. Baltimore, Md. 21225 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between mset and Seth Immediate Cause (Final ∲nysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to // r as a consequence of) Exam attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No icate has t een signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ demenha Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2011 thuism Kathavine 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eutaw St. Joseph Ricky Hospia

State

Registrar

31. Date filed (Month, Day, Year)

9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ INDEL Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN Social Security Number Sex 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday **Funeral** 1 - M 2 X Months Davs Hours Min Country 047017 1928 83 MD Director 213-26-8507 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Tyes 2 XNo BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral or items 23a 9122 RUTH ELDER LANE 21208 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes Give "natural", 3 Wildowed 4 Divorced WHITE Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) EXPORT MANAGER EXPORT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ၉ SMITH KATE ROSENBERG PAUL 19a, Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a 9303 COUNTESS DRIVE, OWINGS MILLS, MD WENDY ELOVER/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) 05/18/2011 BALTIMORE, MD Signature of Funeral Service License SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2 NO disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or se a consequence or): If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last the attending physician To the Hospital or Attending Physician: The law requires that the death certificate be to within 24 hours after death.

To the Hospital Director. After this certificate be to complete of filteral Director. After this certificate. Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy signed by the atte in the past 12 months? Month Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 0 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 30. Name and address of son who completed cause of death (Item 5 31. Date filed (Month, Day, Year) State MAY 1 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ LINDER 16, 2011 11:02 A M SEYMOUR M MAY Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** BALTIMORE N/A SINAI HOSPITAL 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Country) 1 X M 2 🗆 F 85 NY 118-18-3141 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State within 72 hours after death with the Maryland Director CATONSVILLE BALTIMORE 1 Tes 2 No MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21228 1902 TADCASTER ROAD 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Yes, Give WHITE 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) CHEMICAL RESEARCH CHEMIST should be filed what and Mental Hyg 7 is marked othe 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LINDER ၉ STARKMAN HYMAN SADIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1902 TADCASTER ROAD, CATONSVILLE, MD, 21228 . Page 1 and 2 sh tment of Health a tant: If item 27 is ELISE LINDER/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) REISTERSTOWN, MD OHEB SHALOM MEM PARK D5/18/2011 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Liceo 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. et and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending posterior as IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy
5 Other (specify) Year in the past 12 months? Month Day Pregnant at time of death n signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HEARS 2 No 3 Probably 4 Unknown Completed should t 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has the page 2 s autopsy death? certificate | 1 Yes Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 2 After this 28a. Date of injury (Month, Day, Year) eted filled in by the funeral 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 27. Manner of Death Certificate: injury Natural 5 Pending death. Accident Investigation 6 Could not be within 24 hours after deat Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29b. Signature D31136 MAY 16, 2011 34 W. BELVEDERE AV., BAGINAS, MOZIUS address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

RE	J.		State of Mai 21 per fh,g						ible. 011 16064	
Physic	an/	1. Decedent's Name (First, Middle Mabel E.	, Last) Mitchell				2. Date of Death Month	Day	Year 2:100 M	
Med Exam	ical	4a. Facility Name (if not institution, Good Samaritan	, give street and number)			or Location of Death	I may	4c. County	/	
Funera Directo		5. Social Security Number 216–24–1947	6. Sex 7. Age (In yrs. last birthda	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) 05/28/1	Year) 91 9	9. Birthplace (State or Foreign Country) MD	
yland -f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County MD Howa	_	10c. City, Town or E111co t	Location tt City				10d. Inside City Limits 1 ★ Yes 2 □ No	
th the Mar 3a or 28a t be notifi	ral Director	10e. Street and Number 8799 Frederi	ck Road		10f. Zip Code 21043		10g. Citizen of What Country?			
Baltimore, Maryland 21215-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	12. Was Decedent Even Armed Forces?	1	13. Was Decedent of H If Yes, specify Cub 1 Yes 2 N	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American Indian, k, White, etc. White	
215-UC nin 72 hours nen "natura e Medical E	Completed	15. Decede	nt's Education est grade completed) College (1-4 or 5+)	(G life	ecedent's Usual Occu ive kind of work done e. DO NOT use retired blic Servi	during most of wor)	king	16b. Kind of Business Industry Hospital		
Maryland 21215-0036 2 should be filed within 72 hours after tth and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	To Be C	17. Father's Name (First, Middle, L Edward Legg		Pu	DIIC Servi	18. Mother's Nan				
Maryland 2 should be file alth and Mental I 27 is marked or traumatic eve		19a. Informant's Name/Relations David Mitchel	hip (Type, Print)	19b. M	lailing Address (Street	t and Number or Ru.	ral Route Number,	City or Town, S	itate, Zip Code) 21043	
Baltimore, permit. Page 1 and Department of Heal Important: If item 3		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (3	3 ☐ Removal from State Specify)	cemetery,	isposition (Name of crematory or other place Crematory	05/2	23/2011	Baltimo		
Baltimo permit. Page Department o Important: If any injury or		21. Signature of Funeral Service Gregory J.	Licensee Gonce per D	7R	22. Name and Addr	ess of Facility G.	J Gonce F Pasader	Tuneral	Home, PA 21122	
be executed Examine Strian and Striansit	Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	aab	cons quence of):	EPSIS RACT I				Interval Between Onset and Death	
DIVISION Of VITAI HECOTICS, P.O. BOX 08/00 To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome o 1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal death	3 Ectopic pregna 5 Other (specify)					
es that the signed by the detach		Dert II Other significant conditi	ons contributing to death bu	t not resulting in t	the underlying cause of	given in Part I.	23e. Did tol		3 ☐ Probably 4 ☐ Unknown	
(ecord; he law requi te has been age 2 should	Completed by	peripheral v	ascular disea	se, Ver	ious, arter	1 Yes 2 No 3 Probably 4 Leg 2 No 3 Probably 4 Leg 2 No 3 Probably 4 Leg 2 No 3 No 3 No 3 No 24b. Were autopsy findings prior to completion of death? 1 Yes 2 No 1 Yes 2 No No				
cian: T cian: T ertifica ector, p	Be	25. Was case referred to medical examiner?	Hospital:		10	Place of Death (Che	***************************************			
Physic Physic This c	은	1 X Yes 2 No 27. Manner of Death	1 🔀 Inpatie 28a. Date of injury	/ 28b. Tin	ne of 28c. Inj	4 □ Nursing I ury at	rsing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
LIVISION OT VITAI HECOTAS, tal or Attending Physician: The law requires rs after death. In pirector After this certificate has been signed in by the funeral director, page 2 should be in by the funeral director, page 2 should be a second to the funeral director.	Certificate:	3 Suicide 6 Could	tigation		ork? Yes 2 No	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
te Hospital n 24 hours e Funeral I	Medical	(Chaple 2 Medical	g Physician: To the best of r Examiner: On the basis of ex g Nurse Practioner: To the b	amination and/or i	nvestigation, in my opi	nion, death occurred	at the time, date ar	nd place, and du	ie to the cause(s) and manner stat	
To th within To th comp		29b. Signature and title of certific			29c. Licer	se number		29d. Date signe	ed (Month, Day, Year)	
		30. Name and address of person Santosh Dhir			pe, Print) POSPITA	56011 Baltime	och Rave	21239	1	
S Regis	tate	31. Date filed (Month, Day, Year)		r's Signature	arkel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 4:40 PM Gerald May 2011 15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner HOSPITAL HARDOR N/A Baltimore 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Hours Min. Months 1 X M 2 □ F 50 Director 216-72-8259 Jan 21, 1961 Connecticut Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show 1 ☐Yes 2 No Director New Jersey Monmouth Seabright 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1340 Ocean Avenue Unit 64 Funeral 07760 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 10 Never Worked N/A 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be innent of Health and Mental ၉ Gerald Charles MacGuire Betty Jane Thurston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kevin T. MacGuire, Brother Ione Drive Unit B South Elgin, IL 60177 46 If Item 2 or other Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department c Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 05/18/11 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. Homas 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one duse on each line. Immediate Cause (Final OL Alcohol intoxication Complications Acute **Physician** 6 days disease or condition resulting in death) Carolfallan wo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER law requires that the death certificate be executed Box 68760. sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔣 Unknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Physician: The page certificate 1 ☐Yes 2. No 1 ☐ Yes 2 ☐ No of Vital this certific al director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After Division Hospital or Attending 1 Natural 5 Pending found on bus intoxicated death. investigation 1 ☐ Yes 2 X No May 9 2011 22:23 n 24 hours after death.

He Funeral Director: A pletely filled in by the f 2 X Accident 6 □ Could not be 3 Suicide lace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 698 PATAPSCO AVE, BALTIMORE, MD, 21237 4 Homicide ROADWAY 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated To the the within 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 MD 15,2011

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD, 3001 South HANOVER Street

POZDEYEV

RES 000

BALTIMORE

MD

21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Sheck 1 M 2011 70 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner mbia Howas Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Aug 1, 1929 578-44-7277 **Director** 81 China Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Howard 1 ☐ Yes 2XX No Savage 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8127 Woodward Street 20763 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Xes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 XXMarried Maryland 21215-0036 1 ☐ Yes 2 🖾 Xio Specify: If Yes, Give Year or Dates Specify: Asian Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Decupation 16b. Kind of Business Industry United States (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Grade 12 College (1-4 or 5+) Aircraft Mechanic Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Jeu Lan Quay Wong Yet King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and come Department of Health a Important: If item 27 in injury or other tr Mee L. Ming wife 8127 Woodward Street Savage, Maryland 20763 Baltimore, 20a. Method of Disposition
1 □ Burial 2 🌣 remation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 4 Donation 5 Other (Specify) ArundelCrematory 5/19/2011 Odenton, Maryland Signature of Funeral Service Licensee Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland M00770 20707 23a. Part 1. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. L only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury and that initiated event resulting in death) Last Due to (or as a consequence of) attending physician by Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year should be detached signed by the g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 Who 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner' Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ျှ 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director, Al 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ within 2 To the F only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, D46120 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10710 Chark-Columbia MO Drive

DHMH 17 Rev 7/2009

Registrar

32. Registrar's Signature

amend \$16b Per FH C915 5/19/2011 IIII Health and Mental Hygiene State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Mattie 315 2011 Mai Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hosp. Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpic Country) SC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 🗆 M 2 😿 F Months Hours 08-10-213-32-7888 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 72 hours after death with the Maryland 10c. City. Town or Location Director MD Yes 2 No NA Baltimore 10e. Street and Number #1013 10f. Zip Code 10g. Citizen of What Country? Funeral 124 W. Franklin Street Apt. 21201 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. African 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: American 3 X Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working iife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "r any injury or other traumatic event, the Med once. Holiday Inn Elementary/Seconday (0-12) College (1-4 or 5+) Chef Henry O. Sowers 8th Grade NA Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Reddon Henry James 0. Sowers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $212\overline{1}5$ 19a. Informant's Name/Relationship (Type, Print) Grand 4000 Clarks Lane Baltimore, Maryland Lisa L. Thomas-Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place)
Cedar Hill Cem. 1 K Burial 2 Cremation 3 Removal from State 05-20-11 Anne ArundelCo,MD 4 Donation 5 Donner (Specify) Wylie Funeral Home P.A. of Juners of rvice Livenuee 22. Name and Address of Facility 21. Signatura 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Phlumonia disease or condition resulting in death) Medical Due to (or as a consequence of): LO MILL VILLE BY MEDICAL EXAMINER CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or Serving Cause (Disease or iinjury Examine Due to (or as a consequence of) law requires that the death certificate be executed for use as the burial-transit attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown 1 Yes 2 9 Unknown completed filled in by the funeral director, page 2 should be detached Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Completed by ax. lard 2 ☐ No 3 ☐ Probably 4 ☐ Unknown catheter 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed death? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Impatient 2 I ER/Outpatient 3 I DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred the Hospital or Attending 5 \square Pending 1 Natural 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10066515 M.D 21044 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard County General 5744 Cedar Lane Columbia Kawat 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 19 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health/and Montal Hygiene Certificate of Death Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Ruth Elizabeth Netter APRIL 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A AGNES HOSPITAL Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 □ X Days Hours 577-36-7774 90 Director 01/12/1921 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Evan Incomust be notified at once. 1 XYes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21215 Funeral 3804 Dorchester Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 🛛 No Specify: ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Secretary Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Georgia Etta Edwards Cornel Haynes Branham ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3804 Dorchester Rd., Baltimore, MD 21215 Wayne Netter(son) altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State on-site Crematory 04/11/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) e of Euneral Service Licenses 365 Brown Jr. Funeral Home PA Wiamo Baltimore, MD 21217 2140 N. Fulton Ave., Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Respiratory Failure** Immediate Cause (Final **Physician** RESPIRATORY FAILER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Seizure Disorder Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed Subdural Hematoma and burial-trar Due to (or as a consequence of) COICAL EXAMINER Records, P.O. Box 68760, the attending physician Physician/Medical CERTIFICATION IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐ Yes 2 ☑ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 AYes 2 D √o Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending latural 5 Pending Injury **Unknown** M Subject fell 1 ☐ Yes 2 XNo 2 Accident investigation To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify)

Assisted Living Facility 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3804 Dorchester RD. Baltimore, MD 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0065383

Registrar

State

SHABBIR

31. Date filed (Month. Dav. Year)

5415 Old Court Rd Suil #101 Randalls rown MD 21133

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A

MAY 17

CHOUDHRY

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ Noon Kester Medical Facility Name (if not institution, give street and nun ocation of Death 4c. County of Death Examiner Rehab Hir e If Under 1 Year If Under 24 Hrs. Date of Day, Ye (Month, Day, Ye 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Min. 1 □ M 2 🔀 F Virginia Apr. Director 220-36-4091 91 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director 1 Yes 2 No Maryland Harford Bel Air 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō ital Hygiene. ed other than "natural", or items 23a or event, the Medical Examiner must be r Funeral 21014 USA 1812 Conowingo Road 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 ₩ Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Page 1 and 2 should be filed within Own Home 10 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental F ည Elizabeth (unk) Sexton Will Sampson Privett injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 1814 Conowingo Road, Bel Air, MD 21014 Avery F. Noonkester / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ott once, 1

Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Harford Memorial Gdn 5-20-2011 Aberdeen, Maryland 21. Signal e Funeral Service Licens 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysiciani ,ear disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day Pregnant at time of death 1 Yes 2 9 Unknown bonkester, Rub Part II. Othersignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 D Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 TYes Hospital or Attending Physician: 724 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other မှ Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Dath 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be within 24 hours after des To the Funeral Directo completed filled in by the Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner, On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number who completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ 05 Month De 2011 8:49p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6948 Brooksmill Rd. Apt 2D N/A Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign **№** M 2 🗆 f Min 0*1112711*3 Maryland 214-38-0748 **Director** 67 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD N/ABaltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6948 Brooksmill Rd. Apt 2D 21215 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2X Married ģ Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Completed Black 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12th Grade College (1-4 or 5+) Freestate Steel Steel Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. William Blackwell Sr. Julia Noel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 19a. Informant's Name/Relationship (Type, Print) Lizzie Noel(wife) 6948 Brooksmill Rd. Apt 2D, Baltimore, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Garrison Forest 05/20/11 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD 21. Signature of Funeral Service Licenses Josephodnes of Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, PA MD 21217 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ Caranoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami that the death certificate be executed pue Due to (or as a consequence of) resulting in death) Last burialattending physician Physician/Medical Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? ρ Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Tyes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perform death? certificate 1 ☐ Yes 2 💢 No Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🔀 Residence 6 Nother (Specify) 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury To the Hospital or Attendir within 24 hours after death. To the Funeral Director; At completed filled in by the fu 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0057256 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 West Belve deve Avenue; Buthmore MD 21215 31. Date filed (Month, Day, NAY 19 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #29dtaRe of Mary and 5 Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Mary Jane Otten 2. Date of Death 3. Time of Death 201 Pay Physician/ May 14, 6:26 A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A 4b. City, Town, or Location of Death Examiner Manor Care Roland Park Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MD ountry) Months Days Hours Min. Sept 24,1929 213-28-3340 **Director** 81 Usual Residence of Decedent permit. Page 1 and 2 should be lined mineral.

Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1XX Yes 2 No UI $I \in \mathcal{N}$ $I \cap \mathcal{N} \cap \mathcal{N}$ Baltimore, Maryland 21215-0936 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 1429 West 36th Street 21211 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 XX0 Black, White, etc. Completed by 1 Never Married 2 Married If Yes, Give 1 ☐ Yes 2 TVNo Specify: Specify: White 3 XXVidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) unknown College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mary Jane Weaver Clarence R. Slenbaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4204 Elsa Terrace Balto, MD 21211 Susan Stein (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2XX Cremation 3 Removal from State Atlantic Crematory 5/17/11 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 3631 Falls Road Balto, MD 21211 Burgee-Henss-Seitz Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line ASCUD immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjur) for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy Be 25. Was case referred to pedical 26. Place of Death (@heck only one) examiner? 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 27. Mann of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 \(\text{Yes} \) 2 \(\text{No} \) Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0069314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mitted Prajapar 8813 Waltham Wood Re Penkertle 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 20<u>11</u> Month Physician/ 5:40 P M May 13 Henry B. Page Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Marley Neck Health & Rehab. Center Glen Burnie Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🌠 M 2 🗆 F 02-06-195 South Months Days Hours Min. **Director** Carolina 149-44-9132 59 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits the Medical Examiner must be notified at 10c. City, Town or Location Director 1 ☐ Yes 2 🌠 No Glen Burnie MD Anne Arundel 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ō 23a Funeral 21060 United States 7575 East Howard Road ritems death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian Armed Forces' Black, White, etc. ò ģ 1 Never Married 2 Married X Yes 2 No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medic at Exar If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic United States Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lloyd Page Hazel Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Page / Ex-Wife Lemon Tree Court Hanover, Maryland 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🗆 Burial 2 ី Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 05-17-2011 Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1/11 Apparelis Road Odenton, Maryland 21113 Funeral Corvice . Sign atur Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause 🛒 each line. Approximate Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of: Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral idector, page 2 should be detached for use as the bunal-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 2 No g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 No 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury work?
1 Yes atural 2 🗌 No Accident
Suicide Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and litle of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) X 5410 - A Ritchie Highway Brooklyn Park, Maryland 21225

DHMH 17 Rev 7/2009

State Registrar

Harjit Singh,

31. Date filed (Month, Day, Year)

MAY

M.D.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ Thomas Perseghin 18 10:52 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 2715 Bagnell Court Edgewood Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, l 1 X M 2 - F Months Min 218-46-6805 Marviand 63 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Edgewood 1 Yes 2 No Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21040 USA 2715 Bagnell Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 X Married 2 X No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important If item 27 is marked other than any injury or other traumatic event the Menter traumatic event the Menter than injury or other traumatic event the Menter than injury or other traumatic event than Menter traumatic Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel 12 years Steel Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Una Mae Lee Frank V. Perseghin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, wife 2715 Bagnell Court, Edgewood, Maryland 21040 Elaine Perseghin 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 21, cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Stanislaus Cem. 2011 Baltimore, Maryland Signature of Funeral Service License Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death shock, or heart failure. List Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to r as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last onsequence Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown the a 9 Unknown ned by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe I be d Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate ! 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 🗌 Yes 2 🗌 No 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the hast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signat 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 32. Registrar's Signature State Darko Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 8 22AM Betty Lee Phillips 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN Square Hospita Rusedal Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 AF Feb. 3, Year) 33 West Virginia Months Days Hours Min, 235-46-9880 78 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 No Maryland Harford Edgewood 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 once. 1712 B. Crimson Tree Way 21040 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14, Race - American Indian Armed Forces? Black White etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: 3 XWidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Switchboard Operator Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Annie Lee Hannah Gailey Stanford Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trina Rash / Daughter 185 Capon Heights Lane, Strasburg, VA 22657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland Bel Air Memorial Gdn 5-20-2011 21. Signatur, plant ral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Due to (or as a consequence of) disease or condition Medical Examiner 90 mins Bradycardic Sequentially list conditions, Examiner if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician a detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by venticular Fibrillation 1 Yes 2 No 3 Probably 4 Onknown within 24 hours after death. To the Funeral Director: After this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No _____ autopsy performed 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Cectifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) RESODOO W OT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patel 9000 FRANKLIN SQUARE DR vaidee Date filed (Month, Day, Year 32. Registrar's Signature State MAY 1 9 2011 Darke Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Kennington 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Baltimor HOS 8. Date of Birth (Month, Day, Year) Oct 3, 1935 Social Security Number If Under 1 Year If Under 24 Hrs.
Days Hours Min. **Funeral** Age (In yrs. last birthday 9. Birthplace (State or Foreign Months 216-32-2528 75 West Virginia **Director** Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Md. Anne Arundel Co Brooklyn Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 301 Church Street 21225 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White "natural", Completed 3 Divorced Year or Dates of Health and Mental Hygiene.
Item 27 is marked other than "nature other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Inspector Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roscoe Pennington Nellie Mullins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Peggy Pennington, spouse Church Street Baltimore, Md. 21225 Baltimore, it. Page 1 a. ∠epartment of He∕ Important: If ? any injur⁄ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 5/17/11 Baltimore, Md. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service P.A. 4001 Ritchie Hgwy Balto. Md. 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Vist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chionic disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death been signed by the should be detached g 🗌 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforn certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No မ 1 Inpatient 2 1 :R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Watural 5 Pending 1 🗌 Yes within 24 hours after death.

To the Funeral Director: A completed filled in by the fi Investigation 6 Could not be Accident 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier Emergency Department 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Q.U.

Registrar

BARNES

31. Date filed (Month, Day, Year)

3001 SUUTH HANDYER STREET.

MARYLAND

HARBOR HOSPITAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 便急 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 6:10P 2811 MAY Robert A. Robertson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Haltimore 4b. City, Town, or Location of Death Examiner Towson Saint Joseph Medical Center . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Sept. Day 28 1943 Days Hours Min. 1 X M 2 🗆 F New York 214-42-1822 Director Usual Residence of Decedent 28a-f shov 10a. State 10h County at 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a Penn. Cumberland Shippensburg 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 17257 Lantern Lane items death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. o þ 1 Never Married 2 X Married X Yes 2 ☐ No f Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify "natural", Specify: White 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry المالية عند عند المالية المال (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chef Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ge 1 and 2 should be file nt of Health and Mental I: I: If item 27 is marked o ပ Hall Doris Oral Robertson other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33 lantern Lane Shippensburg, Pa. 17257 Wife Jean Robertson/ Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 \square Burial 2 $\raisebox{.5ex}{\ifmmode {\mathbb N}\ensuremath{\mathbb N}\ensuremath{\mathbb N}}$ Cremation 3 \square Removal from State Department of Important: If any injury or injury or 5/19/2011 Towson, Maryland Hilltop Service Corp. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service 21204 1050 York Road Towson. Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ ASPIRATION PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Exami Cause (Disease or linjury that initiated events resulting in death) Last RESETRATORY FAILURE Due to (or as a consequence of) inding physician use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death bed 1 P.O. ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed ENCEPHALOPATHY 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s autopsy perform certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes ျှ 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) e Hospna. n 24 hours after death. he Funeral Director. After th 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29c. License number 05.18,2011 D0069989 s of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

DRIVE TOWSON.

OSLER

7601

32. Registrar's Sign

MOI

MAY 1 9 2011

TMTM

M.D

MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Year May Physician/ 7:55 Рм 16 Alexandra Sally Ruocco Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Towson Gilchrist 9. Birthplace (State or Foreign Country New Jersey 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Social Security Number **Funeral** Aug 30, 1 □ M 2 🛛 F ~1°919 91 Director 266-14-5447 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at Director the Medical Examiner must be notified 1 Yes 2 No Baltimore Timonium MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö items 23a Funeral 21093 **USA** 13 Pebble Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc , or þ 1 Never Married 2 Married 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: white "natural" Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate / Builder Developer / 8 injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F permit. Page 1 and 2 should be Department of Health and Ments. Important: If item 27 is marked any injury or any i ည Alexandra Kaczmarczyk Bronislaw Ziemak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Pebble Lane; Timonium, MD 21093 Bernard A. Ruocco Jr. / son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 5/18/2011 4 Donation 5 Other (Specify) Hilltop Service Corp Towson, MD 1050 York Road 22. Name and Address of Facility 21. Signature of Fun Towson, MD 21204 Ruck Towson Funeral Home, Inc. ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Interval Between Onset and Death Immediate Cause (Final Physician/ ADVANCED DEMONTIA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth
4 Pregnant in the past 12 months?
1 Yes 2 No been signed by the atte should be detached for Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 2 No 3 Probably 4 Unknown 1 Yes Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? CEREBRUVASCULAR ACCIDENT 24a. Was an autopsy performed PORIPHERAL VASCULAR DISCASE 1 Yes 2 No • Hospital or Attending Physician: The 24 hours after death. • Funeral Director: After this certificate! 26. Place of Death (Check only one) Certificate: To Be HOSPICE Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of completed filled in by the funeral 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Matural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one)

State Registrar 29b. Signature and title of certifie

1 9 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

046360

6701 N. Chaples STROOT BALTIMORE MOZIZO4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LONG GREEN CTR BALTIMOVE BALTIMOVE 115 EAST MELVES AVE 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours Min. Months Days 1 M 2 W 220-24-5217 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 10a, State show a or 28a-f show be notified at 1 Nes 2 No BaltimoRe Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ILSA Nicholas 21206 4303 or than "natural", or items 23a by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ NO 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐Yes 2 ☐ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify Specify: Black 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BWI Cashier 12+1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce. Jessie S. Shelton George ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ghter 4303 Nicholas Ave Baltimore, MD Robinette White (20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/21/11 Baltinia, maryland water 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vangort. Greens Fineral St 21. Signature of Funeral Service License 5151 Baitu. Balto. MD 21229 Natil Pike 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 52/313 Physician disease or condition resulting in death) /Medical Due to fr as a consequence of) DVOSTHESIS, CHYDNIC Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transIt DINARCES Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached. 23e. Did tobacco use contribute to the cause of death? Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ VASCULAV 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No ANEULIX 24a. Was an autopsy performed? res 2 No HYPRATENSION 1 ☐ Yes the Hospital or Attending Physician: thin 24 hours after death. the Funeral Director: After this certifical mpletely filled in by the funeral director, p. 25. Was cas referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier f, (INDOTER UI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 115 E. MELROSZ AVIZ BALTIMORE, MD R LINDY Black MID
32. Registrar's Signature PINNETH 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mark A. Roary State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2011 160										1 16079		
Physici Medical Exam		Decedent's Name (First, Middle,Last)							2. Date of Dea Month May 12, 2	ath Day Year	3. Time of Death 1321 hrs	
		4a. Facility Name (if not institution, give street and number) Bon Secours Hospital					4b. City, Town, or Location of Death Baltimore			4c. County of N/A	Death	
Funeral Director		5. Social Security N	1	Sex 2 F	7. Age (In yrs.		If Under 1 Year Months Day		in	rth(MM/DD/YYYY) 9/1960	Birthplace (State or Foreign Country) MD	
i ow any						y, Town or Location					10d. Inside City Limits 1 XYes 2 No	
15-0036 filed within 72 hours after death with the Maryland 1 Hygiene. 4 other than "matural", or items 23a or 28a-f show 6, the Medical Examiner must be notified at once.	y Funer		10e. Street and Number 2833 W. Lanvale St.				10f. Zip Code	timore	[1	10g. Citizen of What Country?		
		11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No			21216 1.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							
hours after "natural", e		3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			1 Yes 2 No specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				Specify: Black 16b. Kind of Business/Industry			
212 uld be Menta mark		10th Grade 17. Father's Name (First, Middle, Last)			Bri	.ck Lay		ne (First, Middle, I	Construction Co.			
		James Edward Roary Mary Louise Canty 19a. Informant's Name/Relationship (Type, Print) Parents 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z										
ore, MD ges 1 and 2 sho t of Health and if If item 27 is ther traumati		Mary Ro	osition		20b. om State	Place of Disposi crematory or oth	tion (Name of ce er place)	metery,	Date	20c. Location - 0	City or Town, State	
Baltimore, permit. Pages I as Department of Hee Important: If ite		4 Donation 5 Other Specify: Mt. Zion Cem. 05/18/11 Baltimore 21. Signature of Funeral, Service Licensee 22. Name and Address of Facility own Jr. Funeral Home							Home PA			
Physician Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Approximate Interval Between Onset and Death										
.*'	<u>_</u>											
ed ssit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
P.O. Box 68760, that the death certificate be executed ned by the attending physician and detached for use as the bunfal - transi		d. X UNPENDED AMENDED 23a,27,per me,g916 6-13-11 sm										
	hysician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (Specify) 9 Unknown										
cords, P.O. law requires that the has been signed by	<u>a</u>	Part II. Other signif	icant condition	s contributing to	death but not r	esulting in the ur	nderlying cause g	given in Part I.	1 Yes	2 No 3	Ite to the cause of death? Probably 4 Unknown	
ital Recorcician: The law rescrificate has be rector, page 2 shore	Completed								24a. Was a autop: perfor 1 Yes 2	sy prid m <u>ed</u> ? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 No	
Phys	To B	25. Was case referrence examiner? 1 ✓ Yes 2 27. Manner of Death 1 ▼ Natural	No Pending	28a. Date ((Month,		ER/Outpatient 28b. Time of In	3 DOA Ury 28c. Injur	of Death (Check Other Nursin ry at Work? Yes 2 No	ng Home 5	Residence 6 now injury occurred		
Division Bospital or Attent 24 hours after death Funeral Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home (Specify)				Lome, farm, street	e, farm, street, factory, office building, etc.			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
To the Hospita within 24 hours To the Funeral completely fille	edical	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
		29b. Signature and t		- ~			29c. License O.C.M			May 13, 201	(Month, Day, Year) 1	
DO.		30. Name and addre Donna M. Vii 31. Date filed (Month)	ncenti, MD	Assistant M		niner 900 V	V. Baltimore	Street, Baltir	nore, MD 212	223		
Registr DHMH 17 Rev 1/20	rar	MAY 19	2011	1	A. 14	ORIGINAL		·				
OCME 2006				OCME		O. GOHAKL						

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 25 per me,g915,05/17/2011dhb
Certificate of Death
Reg. No. For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day idretta Month Smith 201 12:00 PM 0 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death Memorial Baltimore ttospital 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth OS Yrs. Hours Min. (Month, Day, 1 □ M 2 😿 F Months MD Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Owlinas 1 🗆 Yes 2 No 10e. Street and Number 10g, Citizen of What Country? Funeral USA 235 Ritterslea Court 21117 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify: Completed 3 ₩Widowed 4 □ Divorced 15. Decedent's Education 16a Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City College (1-4 or 5+) Hyears Elementary/Seconday (0-12) College Communita Professor 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ichard Nea Dovie Grange 19a. Informant's Name/Relationship (Type, Pring 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hill Court Windsor Smith POLIV MILL MD 212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Forest 10/2011 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD 21. Signature of Funeral Service Licensee Vaugno C. Green-Puneral Services 22. Name and Address of Facility Vaug Road x andalistown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart railure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Shysician/ Shock disease or condition resulting in death) heurs Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) EXAMINER To the Hospital or Attending Physician: The law requires that the death certificate be executed Jwithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnal-transi Due to (or as a consequence of) CERTIFICATI Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes Hospital: 2 No Other: ပ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continuing Nurses Fractioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as etalled. (Check 29c. License number 29d. Date signed (Month, Day, Year) Mayam Keshtker AT2438946 05/01/2011 Fahrom JUD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryam Keshtkar Jahromi / Union Mem. Hosp

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** Leo W. Shanks 1au 18 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Saint Aques Balhmore Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 7, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 1**X**□M 2□F Director 89 213-14-8994 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show
any njury or other traumatic event, the Medical Examiner must be notified at
anone. 1 ∐Yes 2X No Director Catonsville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 707 Maiden Choice Lane 21228 Funeral **USA** 12. Was Decedent Ever in U.S. Armed Forces?
1X Yes 2 No 1941
17 Yes, Give Year or Dates: 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: \$ Specify: White 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Enforcement Administrator County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leo William Shanks Eleanor Wiggington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Douglas Shanks, Son 20948 Tanyard Estates Drive Preston, Maryland 21655 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/19/11 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor ^{22. Name and Address of Facility}
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4 therosclerotic **Physician** lulluower disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗀 Ectopic pregnancy Month Day Year n signed by the a Id be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Gastromtestinal Sleeding 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 4100 Hospital or Atter ding Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☑ No funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours off

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

State

Records, P.O. Box 68760,

Division of Vital

SHAMKS,

31. Date filed (Month, Day, 7 2011

Unier

29b. Signature and title of certifie

32. Registrar's Signature

Alejandro

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Villameal

MD

MO

DHMH 17 Rev 1/2001

Registrar

900

29c. License number

D0068107

South Caton Avenue Balturore

29d. Date signed (Month, Day, Year)

18 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death :20PM Manth Physician/ 201 Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution **Examiner** Medica mor ti Mor If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth o. Date of Birth (Month, Day Year) April 19. **Funeral** Days Min Country) Virginia 77 28-38-3094 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturo" any injury or other traumatic average. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Director 1 ☐ Yes 2 😾 No Shenandoah Winchester Virginia 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Funeral **USA** 22601 613 Ewell Street 12. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 No 19 If Yes, Give 10 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1953 þ 1 Never Married 2X Married 1 ☐ Yes 2 X No Specify: 1958 Specify: White 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry during most of working Elementary/Seconday (0-12) College (1-4 or 5+) F.O.E. / American Legion Bartender Be (18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Mae Miller Clarence Edward Stokes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 613 Ewell Street Winchester, VA 22601 Balbina Stokes, Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 05/18/11 Baltimore, Maryland 4 Donation 5 Other (Specify) Metro Crematory Inc. Signature of Funeral Service Licensee Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Preumonio disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of). resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det þ 2 No 3 Probably 4 Unknown disease Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certificate I completed filled in by the funeral director, page 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 \(\text{Yes} 2 No 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 잍 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work? 5 Pending 1 Natural Investigation ☐ Accident ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 10 32. Regiş State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Selby 16.25 PM Irene Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lorien Columbia Nursing Home Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Hours Min New York 84 0577077926 150-18-9984 Director Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Columbia Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5485 Columbia Road #534 21044 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 XNo Specify: If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dietician Healthcare 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve 2 Joseph Williams Albertina Trethrealt 19a. Informant's Name/Relationship (Type, Print) (Daughter)9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 2416; Columbia, MD Albertina Selby-Kimbrough 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🗖 Cremation 3 🔀 Removal from State Chester Rural Cem 05/23/2011 Chester, PA 4 Donation 5 Other (Specify) 21. Signat of Funeral Service Licensee 22. Name and Address of Facility Freeman Funeral Services undun Keeman 4594 Beech Road; Temple Hills, MD 20748 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ OSTEOMYELITIS EW WEEK disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ULCER FEW MUTTHS ACRAL Sequentially list conditions, Examiner if any leading to immedicause. Enter Underlying and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 D 9 Unknown ed by the detached been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nursa, Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) MAY 18, 2011 ルク DEG 62634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HICKGRYRIDGE RD COLUMBIA 10796 21.44

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#20b, perFH G915, 5/19/2011 WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ma 8:49 AM 2011 Leonard Joseph Scheg Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Regional Hospital Laurel rince (seorge aure If Under 1 Year I If Under 24 Hrs Birthplace (State or Foreign Country)
 New York 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Hours 1XXM 2 | I Director 83 1928 116-20-2295 April Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director 1 ☐ Yes 2X No Prince George's Laurel MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 20708 8408 Snowden Loop Court 12. Was Decedent Ever in U.S.
Armed Forces?
1 9 4 8
1X XYes 2 No
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married b Maryland 21215-0036 1 Yes 2 XNo Specify Specify: White Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Field Artillery Officer U.S. Military 12th 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bert Scheq Frances Koch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan M. Gasbarro/Daughter 336 Dameron S. Laurel, MD Baltimore, unk. Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ${f X}$ Burial 2 ${f \Box}$ Cremation 3 ${f \Box}$ Removal from State Sept. 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Arlington, VA **6.** 2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one case on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Myocardial Physician/ disease or condition resulting in death) Medical Examiner 10 vuldr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) and use as the bunal-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for 1 in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) 9 Unknown g Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 X No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: Certificate: To 1 Inpatient 2 KER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title o 29c. License number D22966 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) Laure Regional Hospital, Emergency Dept.

State Registrar Thomas H.

31. Date filed (Month, Day, Year)

Burquieres

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5:21 Physician/ 01 na Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Med ical Center BULLIE Baltimore shing. ton 10 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) December 18, Social Security Number 6. Sex **Funeral** Months Days Hours Country) Mississippi 1 X M 2 D F 425-20-3089 90 Director Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10a, State 10b. County should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Odenton Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21113 2012 Bunker Hill Court ural", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12 Was Decedent Ever in U.S. 11. Marital Status Was Deceuent Armed Forces?

1 Ves 2 No 1944-Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: 3 Widowed 4 Divorced Black Completed Year or Dates. 1946 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Manufacturing Machinist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Lucinda E. Williams Leonard Smallwood permit. Page 1 and Department of Health and M Important: If item 27 is m: 'miury or other traum Page 1 and 2 shoul ment of Health and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2012 Bunker Hill Court, Odenton, Maryland 21113 Darnell L. Young/Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date May 21 2011 Oakwood Cemetery 1 Durial 2 Cremation 3 Removal from State Chicago, Illinois 4 Donation 5 X Other (Specify) Entombrent Mausoleum 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 21. Signature of Funeral Service Licensee Will Elowes M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ard OVMY OS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or linjury physician and sthe burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day ò Other (specify) Pregnant at time of death the Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 🗌 Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed: 1 ☐ Yes 2 ☐ No this certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No 1 🗌 Yes 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 27. Manner of Death Certificate: injury Watural 5 Pending Accident
Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1 🛆 2-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SI

State Registrar 31. Date filed (Month, Day, Year)

9 2011

32. Registrar's Signature

Itimore

Washington

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 2011 5:45 May Kathryn S. Schuler 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Millersville <u>Anne Arundel</u> Knollwood Manor Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours 1 □ M 2 💢 F 01-11-1918 Pennsylvania 183-01-4350 93 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Millersville Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21108 United States 899 Cecil Avenue South 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Home Maker Own Home 12

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Ann

Unk.

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

Approximate Interval Between Onset and Death - 11 years

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must handled.

for State Registrar

10a. State

MD

17. Father's Name (First, Middle, Last)

Daniel Hitner 19a. Informant's Name/Relationship (Type. Print)

Director

Funeral

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Completed

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Physician

/Medical

Examiner

Funeral

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Physician /Medical Examiner

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attending physician

certificate has

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after death

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burial-transi as the t cate has been signed by page 2 should be detacl funeral director

Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

809 Andover Road Linthicum, Maryland 21090 Ronald W. Schuler / Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Laurel
Hill Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State 05-13-2011 Bala Cynwyd, PA 4 □ Donation 5 ☐ Other (Specify) Donaldson Funeral Home & Cr 1411 Annapolis Road Odenton

3a. Parti. Futer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate cause (Final disease or condition resulting in death)

a. 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 TYes Completed 24a. Was an autopsy performed 2 266 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Sursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Manner of Death 28c. Injury at Work? Injury 5 ☐ Pending investigation Matural 1 ☐ Yes 2 ☐ No M 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

within 24 hours a Ó

cause of death (Item 23a) (Type, Print) Tolly atter 32. Registrar's Signature 31. Date filed (Month, Day, Year) park MAY 1 9 2011

las

Name and address of person

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Dath of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 1317 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 1527 N. Stricker Street Baltimore NA Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2XXF Days Hours Min. 07-29-**Director** 79 241**-**40**-**3491 NC Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location death with the Maryland at 10d. Inside City Limits Director notified 28a-f MD NABaltimore XX Yes 2 No 10e. Street and Number 10f. Zip Code ក 10g. Citizen of What Country? ral", or items 23a o Examiner must be Completed by Funeral Stricker Street 1527 21217 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. African 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give SpecifiAmerican "natural", 3 XWidowed 4 Divorced Year or Dates Health and Mental Hygiene. tem 27 is marked other than "natur ther traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Becton Elementary/Seconday (0-12) 8th Grade life. DO NOT use retired) College (1-4 or 5+) Dickinson Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marvin Harrington Alice Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwenevere Scott-Daughter 1527 N. Stricker Street Baltimore, MD 21217 other item 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or oth cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 05-19-11 Metro Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Linen 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or com cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only e cause on ea 🖨 line Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate the File of the Cause (Disease or iinjury Examine Due to (or as a consequence of): physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate beafter death.

Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signated by should be 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s prior to con death? autopsy performed After this certificate 2 NO 1 Ves 25. Was case referred to medica examiner? funeral director, Be 26. Place of Death (Check only one) Hospital 2 X No Other: ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Derth 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital (within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of avanigation and (avanigation and for inventorial). 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 30. Name and address

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 37 Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BLUE POINT NURSING HOME BALTIMORE If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Hours Min 09-20-1933 1 🗶 M 2 🗆 F Yrs Director 217-30-3791 MD 77 Usual Residence of Deceder 28a-f shov filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 XYes 2 No MD BALTIMORE ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe must be Funeral 1035 ELTON AVE. 21224 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, "natural", or iter Black, White, etc. þ 1 Never Married 2X Married 1 Yes 2 If Yes, Give Year or Dates 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced Specify: Completed WHITE the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BLACK TOP LAYER HIGHWAY ADMINISTRATION 6th permit. Page 1 and 2 should be filed wil Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ ANDREW SCHAAF SARA L. FLOWER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DANIELLE MERRITT/DAUGHTER 1035 ELTON AVE. BALTIMORE, MD 21224 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Dremation 3 Removal from State cemetery, crematory or other place, 4 Domation 5 Other (Specify) METRO CREMATORY 05-18-2011 BALTIMORE, MD e of Funeral Service 22. Name and Address of Facility WILLIAM C. BROWN COMMUNITY FUNERAL 1206 W. NORTH AVE. BALTIMORE, MD 2 номе Р.А. Part 1. Enter the disease, of shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ mo disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence oi). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No g 🗌 Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work s after death. 1 \(\text{Yes} 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

19

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05 Month 1 4 ay 2011 12:22A M Marian I. Smith Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8029 Solley Rd. Glen Burnie Anne Arundel Co. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 0372371939 Director 214-52-8745 72 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified Direct MD Anne Arundel Glen Burnie 1 🗌 Yes 2 😾 No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? 23a 8029 Solley Rd. 21060 U.S.A. or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 ☐ Yes 2⅓ If Yes, Give Year or Dates. 1 Never Married 2 XMarried 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XXX Specify: Specify: Black 3 Widowed 4 Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) 10th Grade College (1-4 or 5+) Sales person Sears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Stevenson Corine Garrett 19a. Informant's Name/Relationship (Type, Print)Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8029 Solley Rd., Glen Burnie, MD 21060 Robert N. Smith Sr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State Hall U.M. Church 05/21/11 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service Licensee 305€pHdd∰sofFBFown Jr. Funeral Home PA any 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eact line. Interval Between Onset and Death 100 NUX Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to lor as a consuluence of cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year Month Day Pregnant at time of death Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by IN CRY 1X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No 2 🗆 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Sesidence 6 ☐ Other (Specify) Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔁 🚅 🔁 Type Tifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 16000 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D2011 Physician/ William S. Taylor May 15. 11:26 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Center Towson 8. Date of Birth (Month, Day, Yea Mar. 30, Social Security Number . Age (In yrs. last birthday If Under 1 Year I If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Year) 1<u>925</u> Months 1 🕅 M 2 🗆 F 86 Hours Maryland 219-16-5922 Yrs Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must he matitized as 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1083 Wilmington Avenue 21223 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2X Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) District Advisor Newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Milton Taylor Agnes Lyons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn N. Taylor - Wife 1083 Wilmington Ave., Baltimore, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Meddowride eother place) Memorial Park Rurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May,19,2011 Elkridge, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): (**Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ctopic pregnancy
5 Other (specify) Month Year Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 2 1 1 Yes Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral D Medical

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State Registrar

29a. Certifier

(Check

only one) 29b. Signature a

Date filed (Month, Day, Year)

d title of certifier

KUMAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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SULTE

29d. Date signed (Month. Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Evelyn Μ. Thomas 13, 10:15p^M 2011 May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Heritage Dundalk Baltimore Social Security Numbe 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 219-16-4067 1 □ M 2 🔀 F Months Days Hours November 21, 1913 97 Maryland Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c, City, Town or Location must be notified at 10d. Inside City Limits Director Md. Baltimore Dundalk 1 Yes 2 XNo 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6906 Sollers Point Road 21222 USA filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Examiner o. Black, White, etc. ρ 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White permit, Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Exal Completed 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6 vears Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel J. Minnick Mary A. Sanders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dana Thomas Granddaughter 10705 Glen Court, Glen Allen Va, 23059 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May 20, 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Sacred Heart Of Jesus Cem Baltimore, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk,
7110 Sollers Point Road, Dundalk, 21222 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) ue to (or as **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for eare consequency of Exam Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) detached 9 🗌 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 Yes 2 No To the Funeral Director After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 은 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending death. 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a er e Funeral Direc Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check the within 2 To the certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Place Market

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

192011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Ronald J. TenEyck May 16, 2011 11:00AM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 15301 Wallbrook Court, #3G Montgomery <u>Silver Spring</u> Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** sex 1 X M 2 □ F Months Days Hours Min New York Yrs. 82 Director 127-20-3155 January9, Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🛣 No Montgomery Silver Spring Maryland ŏ 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 15301 Wallbrook Court, #3G 20906 <u>United States</u> items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ō δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 be filed within 72 hours after If Yes, Give Year or Dates. 1947–1949 1 ☐ Yes 2 X No Specify: "natural", Completed Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 3 United States Government Equipment Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည traumatic Howard TenEyck Mary Myers Page 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zij 15301 Wallbrook Court, #3G Silver Spring, Maryland 20906 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trauonce. <u> Josephine E. TenEyck/ Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date wallace Memorial Mausoleun 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🛣 Other (Specify) Entombmen May 21, Clintonville, West Virginia 2011 permit. 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Furneral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Myocardial Infarction Sudden disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Years <u>Atherosclerosis</u> Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician; The law in 24 hours after death.
• Funeral Director: After this certificate has be autopsy performed? Yes 2 X No has le 2 page 2 🗌 No 1 Yes Division of Vital funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 X Yes Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 2 🗌 No ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 2 Accident 1 Yes 2 No Investigation completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 3 | only on 29b. Signature 29c. License number 29d, Date signed (Month, Dav. Year)

State

Registrar
DHMH 17 Rev 7/2009

30. Name and

John

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dress of person who completed cause of death (Item 23a) (Type, Print)

32, Registrar's Signatu

M.D.

Melnick,

D19294

911 Russell Avenue, Gaithersburg, Maryland 20829

May 16, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2.011 Physician/ Month Rheba Colleen Trout P^{M} May 16 50 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fairfield Nursing Center Crownsville Anne Arundel Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 📭 Hours 7-19-1924 86 Director 220-16-0825 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Gambrills Anne Arundel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1076 Snow Hill Lane 21054 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Mental Hygiene. narked other than "r natic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within Homemaker 12 Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked of traumatic even ည James A. Little Laura A. Hahn permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1076 Snow Hill Lane, Gambrills, MD 21054 James A. Trout-son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5-20-11 Finksburg, MD 4 Donation 5 Other (Specify) Evergreen Mem 21. Signature Juneral Service Ligensee 22. Name and Address of Facility Fletcher Funeral Home homas 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line, Immediate Cause (Final Physician/ disease or condition resulting in death) Medical or as a consequence of Examiner Sequentially list conditions Examiner If any, leading to immedicause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death Other (specify) 4 ☐ Pregnant a 9 ☐ Unknown 1 ☐ Yes ∠ y 9 ☐ Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by een signe rould be d Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown een. 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an pege 2 s After this certificale has autopsy performe Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 2 X No မှ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed within 2 To the F 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar Barne MD21061

mpleted_cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Items 23aft1,25,27,28a-1 per me,8915,05717/2011dhb
Reg. No.

Certificate of Death
Reg. No. Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mayont 6, 2019ay Physician/ 8:15A. Kenneth Withers Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Balto. Examiner Parkville 9900 Walther Blvd. #302 Quail Run Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days April L 12, 1923 214-14-4906 1 XM 2 - F Maryland Director Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Parkville Balto. 28a-f Md. 1 Yes 2 X No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? USA and Mental Hygiene. 'Is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be r Funeral 21234 #302 9900 Waltehr Blvd. permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race ~ American Indian, Armed Forces?

1 Xes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 ₩ Widowed 4 □ Divorced Specify: White Completed Year or Dates. 1942–1946 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Police Officer 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Susie Howard Arthur Withers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Potomac, Md. 20854 1403 Longhill Drive Niece <u>Sharon Ochs</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, Brooklyn, Md. Cedar Hill 15-11-2011 Schimunek Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Nottingham, Md. 9705 Belair road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
Onset and Death
April 2011 shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ematoma Jb disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying AL EXAMINER burial-transi Cause (Disease or linjury CERTIFICATION APPROVED B and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) Day signed by the a d be detached for ☐ Yes 2 L ☐ Unknown a Unknown Part II. Other significant/conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2: autopsy death? 2 🗌 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital: Other: 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 🗶 No 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After iniury 5 Pending 1/2 Natural 2 Accident **Unknown**^M April 2011 Investigation Multiple falls npleted filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number of Bural Route Number, City or Town, State) 9900 Walther Blvd. 28e. Place of Injury - At home, farm, street, factory, office determined Nursing Home Parkville,MD Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year,

State Registrar

Name and address of person

31. Date filed (Month, Day,

Wiegmahn

DHMH 17 Rev 7/2009

Fairmount Ave# 310 Towson MD

who completed cause of death (item 23a) (Type, Print)

515

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 25 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1130 Iams Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UMMC Baltimore 5. Social Security Number Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Country) Jamaica Days 567-50-8686 1 🕅 M 2 🗆 F Months Hours Min. June 14. Year) Director 1936 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6032 Snow Crystal 21044 "natural", or items 11. Marital Status 12. Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired) Electrical Engineer should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 4 Electrical any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gladys Kerr Vincent Patterson permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6032 Snow Crystal, Columbia, Maryland 21044 Rosemarie E. Williams - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia Mem. Park 05/09/2011 Columbia, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ^{22. Name and Address of Facility} Witzke Funeral Homes, 5555 Twin Knolls Road, Columbia, MD M01283 23a. Part 1. Enter the disease shock, or heart fail re. List or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Fir al Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) TCAL EXAMINER Cause (Disease or linjury CERTIFICATION APPROVED BY THE nding physician and use as the bunal-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner?

1 X Yes 2 No Be 26. Place of Death (Check only one) Hospital ၉ Other: 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 0 istrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:05 AM 18 2011 Robert Wayne Wellfare May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Hospital Harford Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 ≥ M 2 □ F Months Davs Hours Min. (Month, Day, Year)
Jul 15, Director Jul 1933 386-82-0650 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits Director 10c. City, Town or Location or 28a-f sl notified 1 Yes 2 No Lake Branch 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? iral", or items 23a o Examiner must be Funeral 49402 United States 9784 Marquette Estates Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: "natural" 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Religion Pastor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ٩ Page 1 and 2 should be ment of Health and Menta Roberta Rosalie Warner Jesse Dorman Wellfare other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Barbara Ann Wellfare /Wife 9784 Marquette Estates Avenue Branch, MI 49402 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) May 19 1 Burial 2 remation 3 Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2011 . Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final AS DINATION DNEUMANIA Physician/ Medical resulting in death) Due to (or at a consequence of) **Examiner** er zight Sequentially list conditions, Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a sumsequence of, use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 So 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 Ves 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Division 2 Accident
3 Suicide Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier ertifying Divisionan: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

If the distance of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check ert ying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated of certifie 29d. Date signed (Month, Day, Year) 29b. Signati DOD563356 who completed ca death (Item 23a) (Type, Print) 30. Name and add 520 Upper Chesapeake Drive Suite 211 Belfir, MD 21014 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 09:00 PM SCHARI LTON 201 05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE BALTIMORE BALTIMORE . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
JAPAN Months Min. 1 M 2 - F Hours 09-07-1950 Director 215-56-0155 60 Usual Residence of Decedent 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 Yes 2 X No BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code ö 10a. Citizen of What Country? 23a Completed by Funeral ral", or items 23. Examiner must 817 PAINTED POST CT. 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian, Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. "natural", 3 Widowed 4 Divorced Specify: Year or Dates. 7/71-11/ BLACK Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) event, the NURSE other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Ith and Mental F 27 is marked or traumatic eve မ RICHARD WALTON DOROTHY WARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a MAUREEN WALTON/WIFE PAINTED POST RD. PIKESVILLE, MD 21208 20a. Method of Disposition

1 Burial, 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN CEMETERY 05-21-2011 BALTIMORE, MD 21. Signa / e of Funer Service Licens Address of Facility
C. BROWN COMMUNITY FUNERAL HOME P.A.
NORTH AVE. BALTIMOE, MD 21217 Part 1. Enter the disease, or coshock, or heart failure. List only pplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph_sician/ Medical Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Vear Pregnant at time of death 2 No To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 😾 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛭 Other (Specify) HOSPICE filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur 201 State

DHMH 17 Rev 7/2009

Registrar

11-03553 Scott Arthur	Sta	e or Print in B ate of Maryland	/ Department	t of Health	n and Mer			ble. 20	11 16098		
	1- For State Registrar	1000	Certificate	of Death	'	12.0	Reg. I	No.	3. Time of Death		
Physician/ Medical Examine	Decedent's Name (First, Middle Scott Ian Ar					Me	onth Death by 11, 201	ay Year 1	1727 hrs		
	4a. Facility Name (if not institution)	4b. City, To	own, or Location		.,,	4c. County of	Death		
	214 Maple Avenue	Federa				Caroline					
Funeral Director	,		ge (In yrs. last birthday	y) If Under Months		s I Mın. I	~ "		9. Birthplace (State or Foreign		
Director	Usual Residence of Decedent	1 X M 2 F	31	Yrs.		M	ay 17 ,	1979	Country) Maryland		
ku a	10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits		
show Inc.	Maryland Carol:	ırg				1 Yes 2 No					
the Maryland a nr 28a-f sh tified at once Director	10e. Street and Number	10f. Zip C	0f. Zip Code 10g. Citizen of What Country?								
th the 133 pr	214 Maple Ave				21632				S.A.		
or death with , or items 23 , must be no	11. Marital Status 1 Never Married 2 Mar	12. Was Decedent	?		Decedent of Hispanic Origin? (Specify Yos, specify Cuban, Mexican, Puerto Rican,			No- 14. Race - American Indian, Black, White, etc.			
Rer de	3 Widowed 4 XDivo	1 Yes 2	X No	Yes 2	No specify	:		Specify:	white		
ours after attural" camine	15. Decedent's Education (Speci	f or Dates: ify only highest grade cor		edent's Usual Od	ccupation (Give	kind of work d	one 16	b. Kind of Busin	ness/Industry		
n 72 h	Elementary/Secondary (0-12)	College (1-4 or	College (1-4 or 5+)			use retired)			played		
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	12 H.S. Grad.	ast)	דת ו	sabilit	,	r's Name (First	Middle Maid		ployed		
215 be filed ntal Hy rked of		·				•		ler F	wing		
21, nould the id Men is mar tic ev	Claude Haynes 19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Ma	ailing Address	(Street and Nur	mber or Rural F	Route Number	r, City or Town,	State, Zip Code)		
Baltimore, MD 21215-0036 Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", in items 23a in 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To B9 Completed by Funeral Director	Deborah Arthur 20a. Method of Disposition	/mother	20b. Place of Dis	Roe St		Green		Maryla	nd 21639 ity or Town, State		
Ore, of He of He	1 Burial 2 A Cremation	3 Removal from St	ate crematory of	or other place)							
Itim it. Pag rtment rtant:	4 Donation 5 Other Spe 21. Signature of Funeral Service L	Cremat 22. Name and Ad					Delaware me, P.A.				
Ba perm Depa Linjur	Kaulebu !	1 hay		12 Sout					me, r.a. Maryland 21629		
Physician	23a. Part I. Enter the disease, or of failure. List only one cause of										
/Medical xaminer	Immediate Cause (Final disease or condition resulting in death)	a. Fentany1 Due to (or as a cons	Intoxicate equence of):	ion		-			Death		
	Sequentially list conditions, if any, leading to immediate	b.									
ted nsit Examine	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a cons	equence or).								
Exa ed	events resulting in death) Last	Due to (or as a cons	ue to (or as a consequence of):								
Sox 68760, leath certificate be executed e attending physician and for use as the burial - transit ysician/Medical Ex	X UNPENDED	d. X AMENDED 23a	.27.28a-f	Der me.	. e915 5-	-25-11	STR				
). Box 68760, the death certificate be executed by the attending physician an other for use as the burfal - tr	IF FEMALE:	23c. If yes, outco	,27,28a-f ,18 per ff	i'g917 7	7 <u>28-11</u> v	/t		23d. Date of de	elivery		
687 ertifice ding p e as th	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2	Fetal death	3 Ectopi	c pregnancy		Month	Day Year		
lox eath creath creath creath creath creath creath creath createn for use	1 Yes 2 No 9 Unkr	· L	time of death 5	Other (Specify	ý)						
p.O. B that the d detached detached by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?										
res that signed be deta							1 Yes	2 No 3	Probably 4 V Unknown		
Records, I ; The law requires ficate has been sig , page 2 should be Completed						17	24a. Was an autopsy		ere autopsy findings available or to completion of cause of		
lecc he lav ate ha age 2						1	✓ Yes 2		ath? ✓ Yes 2 No		
Vital Records yyician: The law requir this certificate has been a director, page 2 should o Be Complete	25. Was case referred to medical examiner?	26.	26.Place of Death (Check only one)								
of Vital Recing Physician: The After this certificate Uneral director, page on: To Be Con	1 ✓ Yes 2 No		ent 2 ER/Outpat			Nursing Hon		sidence 6 🗸			
Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate by its after death. al Director: After this certificate has been signed by the attending physicied in by the funeral director, page 2 should be detached for use as the bur stification: To Be Completed by Physician/Mec	27. Manner of Death 1 Natural 5 Pendir	28a. Date of Inju (Month, Day,)	'ear)	1 Yes 2 V No			28d. Describe how injury occurred				
Atter Atter or death by the icati	2 Accident Invest	igation 11 5-11	fd 5-11-11 unknown 28e. Place of Injury - At home, farm, street, fac			actory, office building, etc. 28f. Loc			known Location (Street and Number or Rural Route Number, City		
Division o spital or Attending tours after death. ocral Director: After filled in by the fune Certification:	3 Suicide 6 Could 4 Homicide	,	or Town, State) 214 Maple Ave. Federalsburg, Md.				ple Ave.				
Division of Vital Records, P.O. Box 68760, Ta the Bospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Fuocral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tranedical Certification: To Be Completed by Physician/Medical	29a. Certifier 1 Certifying Phy	sician: To the best of m				ace, and due to	the cause(s) and manner a	s stated.		
To the How within 24 h To the Fuc completely		iner:On the basis of exa and manner stated.	mination and/or inves								
≥	29b. Signature and title of certifier	C		290. L	License number		29	ou. Date signed	(Month, Day, Year)		

State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

32. Fegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Year)

O.C.M.E.

May 12, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May 8, 2011 4:44 p.m^M Frances Ashley Medical Jean 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's 3655 Halford Lane Hollywood 8. Date of Birth (Month, Day Aug. 19 **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Year) 1937 Mary Land Days 1 □ M 2**X** F Months Hours Min **Director** 73 Yrs 214-34-6585 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 1 Yes 2x No St. Mary's <u>Maryland</u> **Hollywood** 10e. Street and Number 10f. Zip Code ò 10g, Citizen of What Country? must be i Funeral U.S.A. 23655 Halford Lane 20636 items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, the Medical Examiner Black, White, etc. ō 1 Yes 2 No If Yes, Give Year or Dates. δ 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examiury or other traumatic event, the Medical Examiung or other traumatic events and the state of Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Marie Elizabeth Pilkerton Jones John Hilary Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20636 23655 Halford Ln., Hollywood, Floyd F. Ashley / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/13/2011 Mem. Leonardtown, MD <u>Charles</u> Gardens 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Signature of Funeral Service Licens Edward N. Brinsfield 20650 MO0052 22955 Hollywood Road, Leonardtown, MD Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death PROUTE Ph_sician/ MYELOID LEUKEMIA Years disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of, Exami attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year the a 1 Yes 2 P 9 Unknown been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 N 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) မ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completed filled in by the fu Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

MOSPITAL

25500 VOINT LOOKOUT Rd, LEONAR TOWN,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAY 1 1 2011

ST. MARY'S

Kegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day MAT4 2019 0006 AM Bonnie Jeanne Amalfitano Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Washington County Meritus Medical Center Hagerstown cial Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 086-54-9896 Days 1 🗆 M 2 🗓 F Months Hours Min. New York 49 Jully 7 24 1961 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 Yes 2 No ò 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 13508 Olde Saybrook Circle 21742 filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. , or þ 1 Never Married 2 Married Black, White etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", Completed 3 Divorced 4 Divorced Specify: White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Personal Residence Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nathan Berger Irene Smith Berger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 13508 Olde Saybrook Circle Hagerstown, MD 21742 Thomas G. Amalfitano-husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State B'nai Abraham Cemetery 5-10-2011 Hagerstown, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition ROBABLE Medical resulting in death) Due to lor as a consequence of Examiner Sequentially list conditions, Examiner that it, leading to the rediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a soll sequence on. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been sloned by the attending physician and burial-transit resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 No detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy To the Funeral Director: After this certificate I completed filled in by the funeral director, page performed death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Tes 은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 1 Yes 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY Physician/ 2011 EDWARD WILLIAM 6:10A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 6. Sex 1 **X** M 2 □ F Social Security Number If Under 1 Year I If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Hours NOV 29 1945 212-44-7286 65 Maryland Director Usual Residence of Decedent 28a-f shov 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location Director Maryland Frederick Knoxville 1 Tyes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Chick Lane 3540 21758 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗆 No If Yes, Give 196 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1967-1 ☐ Yes 2 X No Specify: White "natural", Completed 3 🗌 Widowed 4 🗌 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Electrical Company other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Madeline unknown Stem 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Tami Allnut / wife 3540 Chick Lane / Knoxville, Maryland 21758 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Brownsville Cemetery 05/06/2011 Brownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home, P.A. 1100 North Maple Ave ./Brunswick, MD 21716 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. 23a. Part 1. Enter the disease, shock, or heart failure. List only Immediate Cause (Final disease or condition Onset and Death Ph_sician/ Ischemic Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or imjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the at d be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autonsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) edine Ubndey, M.D. 5-3-2011 MIDD 64910 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, MD Pratima Pande 15 + 1VA 400 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MAY ARCHACKI 2011 STANLEY Pм 2:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death CONOWINGO **Examiner** 4c. County of Death CONOWINGO VETERANS CENTER CECIL If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthpia Country) PA 9. Birthplace (State or Foreign **Funeral** 195 05 9841 94 Months Days Hours DEC 21, 1 🕅 M 2 🗆 F **Director** T916 Usual Residence of Decedent shov 10a. State Examiner must be notified at 10c. City, Town or Location CONOWINGO 10d. Inside City Limits Director CECÍL MD 28a-f 1 Yes 2X No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a (Funeral USA 21918 775 RAGAN ROAD items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black, White, etc. 1 X Yes 2 □ No If Yes, Give 1942 − 1945 Year or Dates. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. ō ò 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify: "natural", 3X Widowed 4 ☐ Divorced Completed other traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) MACHINE OPERATOR MACHINES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARY ANN DYPTULA IGNATIUS ARCHACKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO BOX 264, NOTTINGHAM, PA 19362 ANNA MARIE ARCHACKI 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State LINWOOD, PA MAY 10,2011 LAWN CROFT CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensea 22. Name and Address of Facility MEALEY FUNERAL HOMES, PO BOX 2866, WILMINGTON, DE M00784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical o (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, Exami that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death Yes 2 🗌 No signed by the a d be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, or Attending Physician; The law requires 2 No 3 Probably 4 Completed 1 Yes Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Tes 2 No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work?
1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Made

31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

32. Registrar's Signature

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Run RD, Balto

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 03^{Day} 2011^{Year} Sallie Mae Anderson 10:58 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Prince George's Cheverly If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2X F 1073774919 Dublin Ga. **Director** 91 242-09-3237 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Md. P.G. Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 114 Staton Drive 20774 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, et þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry $H_{ullet}U_{ullet}D_{ullet}$ (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Financial Processor D.C. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Robert Butler Gertrude Wilcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Edward T. Anderson/Son 114 Staton Drive, Upper Marlboro, Maryland 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 05/12/11 Ft. Lincoln Cem. Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Henry S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D. Signature of Funeral Service Licenses au nall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) Medical Due Examiner Sequentially list conditions, if any, leading to immediate cause. Line Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of tor. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 youths? Day Pregnant at time of death g 🗌 Unknown g Unknow Part II. Other significant conditions contributing of death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy-perform 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 1 은 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Mannar of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) injury 5 Pending 1 Tes 2 No cident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title (Month Day, Year) 29c. License number 29d. Date signe of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ April Day 2011 Alsobrooks 1:00P M T. 25 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 12001 Nevin Lane Fort Washington Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Trinidad 1 □ M 2 □XF Months Hours Min. March Director 579-88-0841 66 1945 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD PG Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12001 Nevin Lane 20744 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedon. ____ Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify:Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Griffith Fredrick Alban Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12001 Nevin Lane
Ft. Washington, MD 20744 19a. Informant's Name/Relationship (Type, Print) John Alsobrooks/husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/3/11 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery Brentwood, MD of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Ovarian Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to jor as a consequence of nding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 month Month Year Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2 No 2 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work 1 Tyes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

CR 6

State Registrar 31. Date filed (Month, Day, Year NAY) 6 201

DHMH 17 Rev 7/2009

M.D., 2101

medical Park Dr. #200, Silver Saina.

erson who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieng For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lillie Virginia Axline May 11, 7:10 PMM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Monteuve Home Frederick Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 91 218-30-7790 1 □ M 2 🂢 F Yea 1919 Nov. Day Maryland **Director** Usual Residence of Decedent show with the Maryland 10a. State 10b. County 10c. City, Town or Location notified at rector 10d. Inside City Limits 28a-f Maryland Frederick Brunswick 1 Yes 2 □ No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. er than "natural", or items 23a of the Medical Examiner must be Funeral 1100 Peach Orchard Lane 21716 within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify.White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO,NOT useratived)
Bank Teller 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Banking permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other tany injury or other traumatic event, thomes. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joshua W. Lapole Mary Fawley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3652 Lander Road, Jefferson, MD 21755 Richard F. Ott, son 20a. Method of Disposition
1 ☐ Burial 2 Å Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Smithsburg Crematory May 16, 2011 Smithsburg, MD 4 Donation 5 Other (Specify) Signature of Funeral Fervice Licens 22. Neemeydrand Felesford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Athero Sclerosis Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Aortic Valve Stenosis Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death). Let Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Year Pregnant at time of death Unknown Dav 5 Other (specify) signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Xunknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has ral director, page 2: autopsy performed? 1 Yes 2 X No 1 ☐ Yes 2X No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: မှ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 X Natural e Hosp. n 24 hours after deatn. he Funeral Director: Aft 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hor To the Fune completed fi (Check only one 3 Contrying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) D 47951 May 13, 2011 the same 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

74

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

Sibte A. Kazmi, M.D., 814 Toll House Ave., Frederick, MD 21701

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:00 PM Julianna R. Balent 07, 2011 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Caroline Denton Envoy of Denton 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 27, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1918 Pennsylvania 1 ☐ M 2 🗶 F 92 209-30-8222 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f show the Medical Examinat must be notified at Caroline Maryland 1 ☐ Yes 2 X No Denton Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21629 United States 1160 Osprey Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: <u>م</u> 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Caterer 11 marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be file I Health and Mental H tem 27 is marked oth Be Zaprzalka Clara Joseph Tabish ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1160 Osprey Lane, Denton, MD 21629 Judith Anne Morsy/Daughter If item 2 or other Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 permit. Pages Department of Important: If it any Injury or o 1 Burial 2 Cremation 3 Removal from State Mon Valley Mem. Park May 11,2011 Donora, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Frampton Funeral Home 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee Esken 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** TAGE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed and Due to (or as a consequence of): burial-Box 68760. attending physician for use as the buria Physician/Medical faw requires that the death certificate IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 □ Yes 2 No Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown à s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ ATHERD SCILLOTIL CARDIO VASCYLAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? PERTENSION EMPHYSEMA. 24a. Was an cate has by page 2 s autopsy within 24 hours after death.

To the Funeral Director: After this completely filled in Proceed. certificate 1 □Yes 2 No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

MAY 1 0 2011

ORIGINAL

MD312 BLOOMINGDALE AUE

who completed cause of death (Item 23a) (Type, Print)

186

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2011 NANCY SHANNON CRITCHLOW BENITEZ APRIL 26, 9:05 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death TALBOT WILLIAM HILL MANOR **EASTON** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MICHIGAN Days Hours Min 1 M 2 X F Months 9/11/1922 88 265-86-3766 Yrs **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 □ No MD TALBOT **EASTON** 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 117 EAST DOVER STREET, APT. 201 21601 USA or items 72 hours after death 13. Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married WHITE 1 Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 X Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ MARGARET EVANS JOHN N. CRITCHLOW traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra JOHN R. BENITEZ, SON 70 EUDORA STREET, DENVER, CO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION 4/28/2011 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 21. Signat Fun LService Licens 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P
200 SOUTH HARRISON STREET, EASTON, MD 21601 Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Approximate Interval Betw shock, or heart failure. List only one caus Immediate Cause (Final Onset and Death Ph_sician/ EREBROVASCULAR INFARCTION disease or condition resulting in death) Medical **Examiner** CARDIOVASCULAR DISBASE LLEROTIL Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical attending physic I for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? Completed by PROCERHALUS, HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown cate has been signated bage 2 should b ANEMIA, LUNG MASS 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy perform 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury at work? 1 🗌 Yes 2 🗌 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year)

ATTENDING ON D who completed cause of death (Item 23a) (Type, Print)

28a. Date of injury (Month, Day, Year)

BLOOMING BALE

DD05309

State Registrar

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Certificate:

Medical

this

within 24 hours after death.

To the Funeral Director: A completed filled in by the fu

31. Date filed (Month, Day, Year) APR 28 20

2 No

5 Pending

Investigation 6 Could not be

determined

27. Manner of Death

1 🔀 Natural

3 Suicide
4 Homicide

only one) 29b. Signature and title of certifi

29a. Certifier

Accident

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Shirley Ann Brake Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown Social Security Number 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date (Month, Day 29 **Funeral** 1 M 2 X Months Days Hours Min. Day, Year) Director 189-30-5924 1939 Honey Brook. Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No PΑ Franklin Waynesboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 215 Ridge Ave. 17268 US death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian Armed Forces?
1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 9 1 Never Married 2 Married Completed by 72 hours after Yes Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give 3 🗆 Widowed 4 🗆 Divorced "natural", white Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene, Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) clerk <u>dept. store</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William J. Lewis Maud Killian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Brake Ridge Ave. Waynesboro, PA 17268 Baltimore, 20a. Method of Disposition
1

→ Burial 2 □ Cremation 3
→ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State any injury or 4 Donation 5 Other (Specify) Green Hill Cem. May 14, 2011 Waynesboro, PA 21. Signate of Funeral Service Lensee 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc 50 S. Broad St. Waynesboro, PA 17268 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 2 Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine and that initiated events Due to (or as a consequence resulting in death) Last burial attending physician Physician/Medical that the death certificate be the as IE FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🕱 No ò Month Pregnant at time of death be detached 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, The law requires 2 No 3 Probably 4 Unknown Completed the funeral director, page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy certificate 2 No 1 Yes or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 24 hours after death Funeral Director: A Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Hospital Medical 29a. Certifier 📆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. To the F To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D44996

Registrar

31. Date filed (Month, Day, Year) State 0



MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Marylar		artment of I <i>tificate of I</i>			giene Reg. No.2 0 1 1	16109		
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day Year	3. Time of Death		
and the same	Medic	cal	Jessica Nico 4a. Facility Name (if not institution, give st			4b City Town o	r Location of Deat	May 7, 2011 5:55p.				
	Examin	lei	Hospice of St.			Callawa			St. Mary			
4	Funeral Director	Г	5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) 24 Yrs.		If Under 24 Hrs Hours Min.	8. Date of Birt July 8,	9. Bi	rthplace (State or Foreign ountry) y Land		
	w=		Usual Residence of Decedent					bury 0,	1700 [1141			
	ıryland I-f sho ied at	ctor	10a. State 10b. County Maryland St. Mary		ty, Town or Loc					10d. Inside City Limits 1 Yes 2 No		
	the Ma or 28a e notif	Dire	10e. Street and Number	5	mechani	10f. Zip Code			10g. Citizen of What C			
	s 23a nust b	Funeral Director	29997 Douglas Circ	le		20659	_	U	nited Stat	es		
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	li li	Vas Decedent of H f Yes, specify Cuba	an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi Specify:			
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Maryland	ould by mark marki		Hank Robert Barry 19a. Informant's Name/Relationship (Typ)		19b Mailin	an Address (Street		Louise	Call r, City or Town, State, Z	in Codel		
	id 2 sh ealth ar n 27 is er trau		Yvonne Barry/Mothe		1	-			csville, M			
Baltimore,	Page 1 ar nent of He ant: If iten ary or oth		20a. Method of Disposition 1	demoval from State Bri	Place of Dispo cemetery, cren insfiel	sition (Name of natory or other place d-Echols	Crem.	May 9, 2011	20c. Location - City o			
Balt	permit. Departr Import any inji	. ,,	21. Sonatale of Funeral Service Licensee	MOO8				insfield	H., P.A., 1, MD 20622			
4	Physician/		23a. Part 1. Enter the disease, or complishock, or hear failure. List only one Immediate Cause (Final disease or condition	cations that caused the deat cause on each line.	th. Do not ente	er the mode of dyir	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death		
	Medical Examiner		resulting in death)	Due to (or as a conseq								
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	cuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events									
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68760	tificate ng phy as the	Medi	IF FEMALE:									
Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Vs 2 No 9 Unknown	3c. If yes, outcome of pregnance 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🛚	Ectopic pregnand Other (specify)	су		23d. Date of de Month	elivery Day Year		
ls, P.O.	uires that the signed by the signed by the details and be detailed by the signed by th	by	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause gi	ven in Part I.		obacco use contribute t	o the cause of death? Probably 4 Unknown		
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Division	tal or Att	l Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	e 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
-	he Hospi in 24 hou he Funeri pleted fille	Medical	(Check 2 L Medical Examine	eian: To the best of my know er: On the basis of examination Practioner: To the best of m	n and/or invest	igation, in my opini	on, death occurred	at the time, date a	nd place, and due to the	cause(s) and manner stated.		
			29b. Signature and title of certifier	Jany		29c. Licens	532	7	29d. Date signed (<i>Moni</i>	th, Day, Year)		
Solu	e		30. Name and address of person who cou					10000				
	Sta	te	Dr. Manoj Panwala 31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture		otte Hall	L , MD 206	044			
	Registra		MAY 1 1 20	111 Serma	1 4	0.00						

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Month Physician/ Burke Edna 30. Apri1 12:10 and Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Golden Living Nursing Home Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Date on L... (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF 88 017-18-9896 Massachusetts Director June Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at death with the Maryland Director Maryland Frederick Frederick 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 USA 30 North Place rral", or items? 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian. Black, White, etc. þ Yes 2 No Yes, Give 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 white 1 Yes 2 X No Specify Page 1 and 2 should be filed within 72 hours aft ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", ury or other traumatic event, the Medical Exalury or other traumatic event, the Medical Specify. Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Field Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edna Hermance Edward Freehoffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 801 Stratford Way, Frederick, Maryland 21701 19a. Informant's Name/Relationship (Type, Print) Shreve - niece Nancy Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Stauffer Crematory 20c. Location - City or Town, State Date permit. Page 1 Department of I 1 Burial 2 X Cremation 3 Removal from State 5-4-2011 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Sign ature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown PIke, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final TItemo enos 15 MITEN Ph_sician/ Monum Medical resulting in death) Due to (or as a consequence of): Examiner EMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi) Exami Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Live Tetal Con Pregnant at time of death in the past 12 months? Month Day Year 1 L Yes 2 l No detached 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) \supset 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 814 TOIL House-the frederick, MD . 21701 KAZMI MO b 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 30, Day 2011 Physician/ 3:00 P M MARY CATHERINE BURNS Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Frederick Walkersville Glade Valley Nursing & Rehab. Center If Under 1 Year | If Under 24 Hrs. Social Security Numbe Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Aug. 22, Year 911 Days Mary Land 99 Yrs **Director** 214-10-2934 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location be filed within 72 hours after death with the Maryland Director 1 Yes 2 □ No Maryland Frederick Walkersville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21793 U.S.A. 56 West Frederick Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mary Catherine Shultz John Henry Klipp 1 and 2 should be of Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2506 Shelley Circle 2-C, Frederick, MD 21702 Bondena Burns-Jacques/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1X Burial 2 Cremation 3 Removal from State Mt. Olivet Cemetery 5/5/2011 Frederick, Maryland 4 Donation 5 Other (Species 21. Signature of Funeral Service Lic ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. Lul 1201 NORTH MARKET STREET, FREDERICK, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ mer disease or condition Medical resulting in death) Due lo Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown placed massive been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has page 2 perform death? 1 ☐ Yes 2 ☐ No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 船 examiner? Hospital 2 No <u>|</u>2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work?
1 \(\sum \) Yes 2 \(\sum \) No injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ihonson

State

Registrar

4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav Year Physician/ 1845 Finley Eugene Benjamin 204 100 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital 7. Age (In yrs. last birthday) 87 yrs 8. Date of Birth Aug. 23, Year) 1923 9. Birthplace (State or Foreign Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** 1 XM 2 □ F Days Hours New Hampshire **Director** 002-16-5636 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2X No Maryland | Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Funeral 20906 U.S.A. 3608 Ralph Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 2 No 1 ☐ Yes 2 XNo Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates. WWII 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 **yrs** Voice of America Budget Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည McCutcheon Anna Finley Benjamin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4407 Noah Court, Mount Airy, Maryland Finley W. Benjamin - Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematorium 5/02/11 Alexandria, Virginia 4 ☐ Ponation 5 ☐ Other (Specify) Signature of Funeral Services icens 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 26401 Ridge Road. Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Seosis disease or condition resulting in death) Medical r as a consequence of) Examiner 7 0 C Sequentially list conditions. Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying To the Funeral Director: After this certificat¹ has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit atria Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law equires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**0No 1 🔲 Yes 1 Napatient 2 🗆 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 24 hours after deatl Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Eduti 2011 41162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Germantown 20876 19529 MD Doctor's 4 + IVA Vinu Ganti 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 201 0 4 Registrar

DHMH 17 Rev 7/2009

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Finley

enjamin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Brasi 2153 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ACOM160 SALISHURY REGIONAL TENINSULA Medical If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min 1 □ M 2 🕦 F 230-42-5580 Yrs Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No incoteague 10e. Street and Number 10g. Citizen of What Country? Funeral 419 death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. PRMC Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ OScac laylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33336 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Brasule Saxter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 2-2011 Taylor Compley lemper anceville, VA 21. Signature of Funeral Service Licensee Chincotcague, UA 23336 22. Name and Address of Facility any **Funzial** Homz 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events Due to (or as a consequence of) resulting in death) Last bunia!physician the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, æ 26. Place of Death (Check only one) Hospital 2 No Other: 1 🗌 Yes 잍 1 Inpatient ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death. To the Funeral Director; A Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier AC 000361 2011 OTC 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) 100 E. CARRELL ST. Christ HUGSON , NUISE Prochherel 31. Date filed (Month) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 9, 201 Pay Lloyd Ellison Chase 3:15 а м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3398 Broomes Island Road Port Republic Calvert 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last hirthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours (Month, Day, Year) March 6, 1955 **Director** 217-66-0672 56 Usual Residence of Decedent show or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Calvert Port Republic 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? If item 27 is marked other than "natural", or items 23a or or other traumatic event, the Medical Examiner must be Completed by Funeral 3398 Broomes Island Road 20676 USA permit. Page 1 and 2 should be filed within 72 hours after death I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examinar mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 Divorced Year or Dates Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16h Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Madeline Gross John Benson Chase 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 517, Saint Leonard, MD 20685 Doris Hurley - sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Brooks UMC Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🖔 Burial 2 🗆 Cremation 3 🗆 Removal from State May 14, 2011 St. Leonard, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Sewell Funeral Home, P.A. 22. Name and Address of Facility 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Metastatic rectal course Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated at Certifying Nurse Practice or To the boil of my included, coeff procured at the time, date and place, and due to the cause(s) and have or a stated (Check within 2 To the F 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 1)56024 a May 12 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Frederick MD 20678 110 Hospital Road Suite 110 Kenneth L. Abboxt 31. Date filed (Month, Day, Year) State Registrar

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		•	For State Registrar				tificate of L			eg. N2 1	16116		
ı	Physicia Medic		1. Decedent's Name (First, Middle, Las Margaret Edna C				2. Date of Deatl MAY	eath Day Year O 520 A M					
	Examin		4a. Facility Name (if not institution, give			Location of Death		4c. County of Death Washington					
	Funeral		Meritus Medical 5. Social Security Number 6. Social Security Number 6	ex 7. Age	e (In yrs. la	st birthday)	Hagers If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bi	rthplace (State or Foreign		
	Director		363-26-2796 ¹ Usual Residence of Decedent	□м 2 Х F	8	9 Yrs.	Months Days	Hours Min.	July 25	,1921 Ohi	.O		
	aryland a-f shov fied at	Director	10a. State 10b. County 10c. City, Town o						10d. Inside City Limits 1 ☐ Yes 2 🗓 No				
	the Ma or 28a	Dire	W. Virginia Berkeley Fall: 10e. Street and Number				10f. Zip Code		1	0g. Citizen of What C			
	h with ns 23a nust t	Funeral	897 Emerson Drive				25419			USA			
36	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces?	1 ☐ Yes 2 🌠 No If Yes, Give		 13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, € 1 ☐ Yes 2 ☒ No Specify: 			14. Race - Am Black, Whi Specify: Wh			
2-0	2 hour "natu edical	Completed	15. Decedent's E (Specify only highest gra	ducation ade co <i>mpleted</i>)				dent's Usual Occupation kind of work done during most of working			Industry		
21215-0036	2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " traumatic event, the Med	Com	Elementary/Seconday (0-12)	College (1-4 or 5+)			o NOT use retired) naker			Home			
	filed wall Hyg) Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle, M	aiden Surname)			
Maryland	uld be I Ment narke	입	Albert Stanley Sc						oyer				
	and 2 sho Health and tem 27 is i		19a. Informant's Name/Relationship (T) Allen P. Partlow	(Son)		4				City or Town, State, Z			
altimore,			20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	Removal from State	20b. P	lace of Dispo emetery, crer	osition (Name of matory or other place	ce)	Date	20c. Location - City o	r Town, State		
tim	permit. Page Department o Important: If any injury or once.		4 Donation 5 Other (Specific	(y)	Hag		wn Cremat Name and Addres				, Maryland		
21. Signatura of Funeral Senice Licensee						100	neral Hom illiamspor	e P.A. t,Maryland					
23a. Part 1. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition							45		or respiratory arre	st,	Approximate Interval Between Onset and Death		
	Medical Examiner		disease or condition resulting in death)	a. Due to (or as a c d equence of):									
	p it	Examiner	Sequentially list conditions, if any, leading to immediate cause. Litter underlying	Due to (or as	Due to (or as a consequence of):								
	be executed sician and burial-transit	cal Exar	Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of):										
09/	cate be physic the bu	d											
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the beautied.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		☐ Ectopic pregnand ☐ Other (specify)	су	23d. Date of d Month	elivery Day Year					
P.O.	that the deg ined by the g e detached i	by Pr	Part II. Other significant conditions of	ontributing to death b	ut not res	ulting in the u	underlying cause giv	ven in Part I.	23e. Did tob	acco use contribute t	o the cause of death?		
rds,	v requires the been signer should be	eted			- 1 N 1					Yes 2 No 3 Probably 4 Unknown			
3eco	he law r te has b age 2 sh	Completed							24a. Was ar autops perforr 1 \(\sum \) Yes 2	prior to completion of cause of			
tal	sician: The la certificate ha rector, page 2	Be	25. Was case referred to medical examiner?	Hospital:				lace of Death (Chec					
of Vi	Physi rthis c raldin	일:	1 ☐ Yes 2 No 27. Manner of Death	1 Inpati	\rightarrow	ER/Outpatie	nt 3 DOA Oth	4 ☐ Nursing H		nce 6 Other (Spe	cify)		
ou c	ath. rr. After	icate	1 Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	(Month, Day		injury	work	Yes 2 No	Zod. Dosonibo no	how injury occurred			
Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	al Certificate:	3 □ Suicide 6 □ Could not b 4 □ Homicide determined						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	the Hospi nin 24 hou the Funer npleted fill	Medical	(Check 2 Medical Exam	iner: On the basis of e	xamination	and/or inves	tigation, in my opinio	on, death occurred a	t the time, date an	se(s) and manner as s d place, and due to the cause(s) and manner a	cause(s) and manner stated.		
0	vith con		29b. Signature and title of certifier	Suef			29c. License	e number 283 65	2	9d. Date signed (Mon	th, Day, Year)		
	W-1		30. Name and address of person who o	completed cause of d	eath (Item	23a) (Type, 1	el Stre	et 1tes	Debeu	1902	1740		
	Sta	te	31. Date filed (Month Day You)	1/	ar's Signat								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DAWSON ARTHUR CARTER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Western MD Regional Medical Center Allegany Cumberland If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/11/192 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 D F Director 221-05-7992 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1XX Yes 2 □ No Allegany Cumberland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 849 Mt. Royal Avenue 21502 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No ģ Baltimore, Maryland 21215-0036 1 Yes 2 X No White 3 Widowed 4 Divorced WWII Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Manager Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Carter Edna Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nada Carter / Wife 849 Mt. Royal Avenue, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State MSVC - Rocky Gap 04/29/2011 4 Donation 5 Other (Specify) Flintstone, MD 21. Signature of Funeral Service 22. Name and Address of Facility Upchurch Funeral Home, P.A. 202 Greene St., Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Atherosclerotic Physician/ Cardiovasalar 2 years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Duc to (or as a consequence of): burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) ned by the at detached for P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? signed I þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director After this certificate has been sign completed filled in by the funeral director, page 2 should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🗷 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) かが woweekstin MD 00055325 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd Cumberland MD 21502 925 Bishop Walsh

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Louis McGrath Carey Jr. Month, 11:53AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Wilomico Salisbury the Lake pice Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 D F Months Days Hours Min. Country) Maryland 214-60-9957 57 .0/24/1953 **Director** Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Salisbury Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 30390 Southampton Bridge 21804 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Supply Owner/Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis McGrath Carey Sr. Anna Belle Kelley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Lynne J. Carey/spouse 30390 Southampton Bridge, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place)
St. John S U.M. 20c. Location - City or Town, State 1 \mathbf{X} Burial 2 \square Cremation 3 \square Removal from State Donation 5 D Other (Specify) 5/3/2011 Fruitland, MD Church Cemetery Signati al Home Professional Association Rd., Salisbury, MD 21804 Rompson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MAHANANT disease or condition resulting in death) CARCINOUNA LUNG Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law 'equires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2/FNo Other: 1 🗌 Yes မှ HOSPICA 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending injury 2 🗆 No 1 Yes Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical f certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 10058410 1 MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21802 po 30p 31. Date filed (Mor aistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Florence Thompson Coleman Month

4b. City, Town, or Location of Death

Clinton

May

01

4c. County of Death

Prince George's

3. Time of Death

<u>4:1</u>2 ^A⋅ M

Physician/ Medical **Examiner** For State Registrar

4a. Facility Name (if not institution, give street and number)

Southern Maryland Hospital

Funeral Dire permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Ph sic Me Exan

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760

neral		5. Social Security Nu		6. Sex 1 ☐ M 2 🕇 F	7. Age (l.	'n yrs. las	t birthday)	If Under 1 Months	Year Days	If Unde Hours		B. Date of Bir		9. Bi	rthplace (State or Foreign	
ctor	578-24-4531											oton, Md.				
ш		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside Cit														
da	5	10a. State	10b. County	1	0c. City,	Town or Lo	cation							10d. Inside City Limits		
otifie	Director	Md.	Char	cles			Waldo	rf							1 X Yes 2 ☐ No	
enc		10e. Street and Num			10f. Zip C	ode				10g. C	Citizen of What C	ountry?				
ust b	Funeral	6306 Fu			20	603	}				U.S.A.					
m m	Ë	11. Marital Status	r in U.S.	13. V	Vas Deceden	t of His	panic O	igin? (Specif	y Yes or No-		14, Race - Am	erican Indian,				
mine		1 🗌 Never Marrie)		Yes, specify				can, etc.)		Black, Whi					
Exal	Completed by	3 🖁 Widowed 4		1 ☐ Yes 2 ☐ YNo Specify:							Specify: Black					
lical	let			nt's Education			16a. Decedent's Usual Occupation 16b. Kind o							L Kind of Business	Industry	
Med	ш	(Spec		est grade complete	1-4 or 5+)		(Give kind of work done during most of working life. DO NOT use retired) H.E.W								,	
the		12th	inday (U-12)	College	1-4 Of 5+)		Offi	ce Adm	uni	stra	itor			U.S. Government		
/ent,	Be	17. Father's Name (F	irst, Middle, L	ast)						18. Moth	ner's Name (F	First, Middle,				
lic e	P	Charles	Arthu	ur Thomps	on		18. Mother's Name (First, Middle, Maiden Surname) Sada Holmes									
пша		19a. Informant's Nar					19b. Mailin	a Address (S	treet a	nd Numb	er or Rural R	oute Numbe	r. City c	or Town, State, Z	ip Code)	
any injury or other traumatic event, the Medical Examiner must be notified at once.		Joan Stew	art/Ni	.ece				Mailing Address (Street and Number or Rural Route Number, 06 Fur Seal Ct.,Waldorf,Mar								
othe		20a. Method of Dispo			I			sition (Name			Dat	e	20c. l	Location - City o	r Town, State	
ry or		1 LX Burial 2 □ 4 □ Donation		3 ☐ Removal from Specify)				t Cem.			05/14	1/11	Tu7-2	chinator	, D.C	
inju		21. Signature of Fun-		icensee		ric.								Washington, D.C.		
any			neral Service Licensee 22. News and Address of Washington & Son 4925 Burroughs Ave., N.E., Wa							ons Wasl	vashington, D.C. 20019					
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximat												Approximate		
		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or cardilla)												Interval Between Onset and Death		
ian/ lical		disease or condition resulting in death) Due to (or as a consequence of):														
iner		Sequentially list conditions, Due to (or as a consequence of): ESOPIHAGEAL CANCER														
	ē	Sequentially list conditions, If any, leading to himnediate b. Due to (or se a corresquence of):												W-		
sit	Ë	If any, leading to firm ediate case. Enter Underlying Cause (Disease or injury)														
-tran	Examiner	that initiated events resulting in death) La		c. Due to	(or as a co	onsequer	nce of:									
ouria																
should be detached for use as the burial-transit	ted by Physician/Medical			d												
se as	Ž	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy														
or us	ian	23b. Was decedent p in the past 12 m		1 Live	death 3	Ectopic pre	gnancy	,			- í	23d. Date of de	Day Year			
ped f	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown											WOTH	Day real		
etac	R	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute											use contribute t	o the cause of death?		
pe	g	MA CONTRACTOR TO A												/		
ono																
2 8	힐											24a. Was autor		24b. Were at prior to	utopsy findings available completion of cause of	
bage	Comple											perfo	rmed?	death?	s 2 1 No	
ctor,	Be (25. Was case referred examiner?	d to medical		,				26. Pla	ce of Dea	ath <i>(Check or</i>					
dire	္	1 ☐ Yes 2 ☑	No	Hospital:	Inpatient	2 🗆 EF	R/Outpatien	3 🗆 DOA	Other	: 4 □ N	ursing Home	5 🗆 Resid	dence	6 Other (Spe	cify)	
Inera	ij	27. Manner of Death 1 ☑ Natural	5 Pendin	28a. Date	of injury oth, Day, Ye	ear) 28	Bb. Time of injury	28c.	Injury work?		280	d. Describe h	ow inju	ry occurred		
he fr	Certificate:	2 Accident	_ Investig	gation				М	1 🗆 Y	′es 2 □	No					
yd	eri:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								281	f. Location (S City or Tou			ıral Route Number,		
completed filled in by the funeral director, page 2		V									12					
≣ ped ‡	Medical	29a. Certifier 1 1 (Check 2 [Certifying	Physician: To the	best of my	knowled	ge, death o	ccured at the	time,	date and	place, and d	lue to the ca	use(s) a	and manner as st	ated. cause(s) and manner stated.	
uplet.	Σe	only one) 3 L	Certifying	Nurse Practioner	To the bes	st of my k	nowledge, d	eath occurred	at the	time, dat	e and place, a	and due to th	e cause	e, and due to the (s) and manner as	stated.	
8		29b. Signature and tit	tle of certifier							number				ate signed (Mont		
		• (')	h		MD			DO	20	64	186		5	11/201	/	
	- }	00.11	-1			l- /la 0/	0-) /T D	:								

State Registrar

Clinton md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL aoi I 2130 elma Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Easton Albo Memoria HOSDI If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours Min 05-11-1935 Maryland **Director** 218-30-1816 75 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland notified at 10d. Inside City Limits Director 1 ★ Yes 2 No Md. Chestertown Kent 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medic I Examiner must be Funeral 21620 USA 203 Lincoln Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. Income Maintenance Superv Elementary/Seconday (0-12) College (1-4 or 5+) Kent Co.Soc.Serv. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F ပ္ Druecilla Tiller Charles Edward Teat, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Lincoln Dr., Chestertown, MD. 21620 Page 1 and 2 shment of Health a tant: If item 27 is Ralph Deaton / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town. State etery, crematory or other place, injury or 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. Bonation 5 Other (Specify) 05-07-11 Chestertown, Md. Signature of Pineral Service License 22. Name and Address of Facility Bennie Smith funeral Home 855 High St., Chestertown, Md. 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line.
Immediate Cause (Final Interval Between Onset and Death Physician/ disease or condition 040 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Yes 2 No 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy nielo ☐ Yes 2 No 1 Yes 2 No Be 25. Was case, eferred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital 1 ☐ Yes 2 ☐No မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation Director; Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and titl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

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Year)

31. Date filed (Month, Day,

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be

			pe or Print in E					-			
		State	State of Maryland	•			лептат нуд	lene	15121		
	_	Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	<i>Jeann</i>	2. Date of Deat	eg. No. U	1016-1		
Physicia	eal ier	Arlene	Fay	Detrow	ī		Month	Day Year 2011	3. Time of Death 3:00 A		
Medic Examin		4a. Facility Name (if not institution, give street	2001011		Location of Death	May 8,	4c. County of Death				
		246 Wyngate Drive			Frede	rick		Frede	rick		
Funeral Director		5. Social Security Number 6. Sex	7. Age (in yrs. las	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov 11,	9. B	irthplace (State or Foreign ountry) ryland				
		215-74-5504	79	Yrs.			Nov II,	1931 Ma	ryland		
shov d at	tor	10a. State 10b. County		Town or Loc					10d. Inside City Limits		
Mary 28a-f otifie	Director	Maryland Frederick		Freder	ick				1 ¥ Yes 2 □ No		
th the	ralD	10e. Street and Number			10f. Zip Code 21701		1	0g. Citizen of What 0	Country?		
ath w	Funeral	246 Wyngate Drive	Was Decedent Ever in U.S.	13 V	Vas Decedent of His	spanic Origin? (Spa	ecify Yes or No-	14. Race - Am	orioan Indian		
or it	by F	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔼 No	lf	Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, Wh			
urs an tural" al Exa		3 L Widowed 4 L Divorced	lf Yes, Give Year or Dates.	1	☐ Yes 2 🛣 No	Specify:		Specify:	white		
72 no n "nat ledica	Completed	15. Decedent's Educat (Specify only highest grade c	ion ompleted)	(Give k	ent's Usual Occupa		ing	16b. Kind of Busines	s In d ustry		
vitnin jiene. er tha the N		Elementary/Seconday (0-12)	College (1-4 or 5+)	None	NOT use retired)			None			
al Hyg	Be	17. Father's Name (First, Middle, Last)	·			18. Mother's Nam	e (First, Middle, M	aiden Surname)			
id be Menta arked atic e	인	Webster Franklin D	n Haupt								
permit. Page I and 2 should be lined within 72 hours after death with the Manyland pergarment of Health and Mental Hygiene. Important: If items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, F						City or Town, State, 2			
Healt Healt tem 2		Elouise M. Harp / S			5 Mohawk sition (Name of			g, Marylar 20c. Location - City o			
age l ent of nt: If ii y or o		1 X Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State cea	metery, crem	natory or other place	e)					
oartm. r		21. Signature of Funeral Service Licensee) Mt.		Cemetery Name and Addres			Mt. Lena, Fer Funera	1 Home, PA		
		> salarn	Del	76	06 Old N	ational I	Pike Boom	nsboro, MI			
		23a. Part 1. Enter the disease, or complicat shock, or neart fallure. List only one ca	ons that gaused the death. use on gach line.	Do not ente	r the mode of dying	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between		
hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Dronary Due to (or as a conseque	Art		isea.			Onset and Death		
Examiner		resulting in death)		2 40:50							
	ner	Sequentially list conditions, b b	Due to (or as a conseque	ence of):	100				2 TECES		
ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events c	Congestive	e H	earl	Failu	re.		6 years		
oian ar urial-tı	cal E	resulting in death) Last	Due to (of as a conseque	1 1	Infar	+			6 210		
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		d	Myocaro	eias	2		o years				
nding use as	Physician/Medi		f yes, outcome of pregnance					23d. Date of d	elivery		
e atte	sicia	in the past 12 months? 1 ☐ Yes 2 🔯 No	1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnancy Other (specify)	у		Month	Day Year		
l by th	Phy	9 LI ONKNOWN		Al i- Al		es la Bast I	T				
signec I be de	þ	Part II. Other significant conditions contrib	chronic						to the cause of death? Probably 4 Unknown		
been should	Completed	By Cheriston S	0 1	MEII	ial rela	rola jirn	24a. Was an	,	utopsy findings available		
e has	duc	seizure disorde	r. Parkir	rasi	5 Pist	ase,	autops:	y prior to ned? death?	completion of cause of		
tificate tor, pa	BeC	25. Was case referred to medical			26. Pla	ace of Death (Check	1 Yes 2	I No 1 □ Y	es 2 No		
lis cer direct	10 B	examiner? 1 Yes 2 No Hosp	ital: 1 Inpatient 2 E	R/Outpatient	Othe	r:	ng Home 5 ☑ Residence 6 □ Other (Specify)				
fter th		27. Manner of Death 1 ✓ Natural 5 □ Pending	8a. Date of injury (Month, Day, Year)	8b. Time of injury	28c. Injury work	at	28d. Describe hov				
death tor: A the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	O- Disse of labor. At how			Yes 2 □ No					
after Direc 1 in by		4 Homicide determined	 Place of Injury - At hom building, etc. (Specify) 	ie, rarm, stre	ет, тастогу, опісе		28f. Location (Str. City or Town,	Street and Number or Rural Route Number, vn, State)			
hours uneral d filled	edical	29a. Certifier 1 Certifying Physician	: To the best of my knowled	dge, death o	ccured at the time,	date and place, an	d due to the caus	e(s) and manner as s	tated.		
the Fu	Σ	only one) 3 Certifying Nurse Pra	On the basis of examination a actioner: To the best of my k	and/or investi (nowledge, d	gation, in my oplnior eath occurred at the	n, death occurred at time, date and plac	the time, date and e, and due to the d	I place, and due to the cause(s) and manner a	e cause(s) and manner stated. s stated.		
P P WITH		29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Mon	th, Day, Year)		
1	-	30 Name and address of several	eted squee of doct (ltare 6	(3a) (Time 17	1042	1641		May 9	2011.		
5	- 1	30. Name and address of person who compl Stephen Lee M	- 11- 1	(lype, Pr	1	Fraker	rh An	1 217	0.3		
State	е	31. Date filed (Month, Day, Year) NAY 2 2011	32. Registrar's Signatur		- A A	I N CULUM					
Registra	ır	MHT EW CUIT	Come 1	J. 1996	100						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Dunkinson, Sr. Robert Myron 11:30 AM May 011 Medical 4c. County of Death Allegany 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cumberland 14012 Cedarwood Drive, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Min. 1 🔀 M 2 🗆 F Hours 246-32-6403 82 Yrs. Director 01/29/1929 Marvland Usual Residence of Decedent 28a-f short 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director MD 1 🗆 Yes 2 🛣 No Allegany Cumberland ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14012 Cedarwood Drive, SW items 23a Funeral 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Staff Sergeant U.S. Marine Corps Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Wiley Byron Dunkinson Ruth Edith Konigmacher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 14012 Cedarwood Drive, SW, Cumberland, MD 21502 Lillie Mae Dunkinson / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MD Vet Cem @ Rocky Gap 05/09/2011 Flintstone, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Alams Family Funeral Home, F.A. Signature of Funeral Ser 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ UNG disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Year Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ DEMENTIA. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) May 4, 2011 D0034812

Registrar
DHMH 17 Rev 7/2009

State

3 and

32. Registrar's Signature

909B Seton Drive, Cumberland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eugene Nallin, M.D.,

31. Date filed (Month, Day, Year)

MAY 0 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 27, 2011 Year Physician/ Richard Franklin Daugherty 12:25 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Allegany Health Nursing & Rehab. Cumberland . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 🕅 M 2 🗆 F Days Hours Min. 82 418-30-3364 Director 03/03/1929 Alabama Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany LaVale 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10214 Shortest Day Road, NW 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give 2 No 1948-Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", 3 X Widowed 4 Divorced Completed 1951 Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Tire and Rubber Manager permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Elmer Daugherty Birdie Gentle Lou 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15405 Shamrock Road, SW, Cumberland, MD Debra L. Kitzmiller/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State Cumberland Crematory 04/30/2011 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 21. Signature of Funeral Service 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of): **Examiner** Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consection to of: and I-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death ☐ Yes 2 ☐ No the g 🗌 Unknown g 🗌 Unknown P.O. þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 No 3 Probably 4 Unknown Completed After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an Hospital or Attending Physician: The law autopsy performed? Yes 2 X No prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 1 Tyes 2 🔯 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? Natural 5 Pending To the Hospital or Attendil within 24 hours after death. To the Funeral Director: At completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ledical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge ath occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) April 28, 2011 R137604 address of person who completed cause of death (Item 23a) (Type, Print) Denise Wilson, CRNP, 730 Furnace Street, Cumberland, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State barket Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month April Rose Dubrow 9:35а м 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Potomac Montgomery Liberty Assisted Living 9. Birthplace (State or Foreign Country) New York 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/17/1915 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days 1 - M 2 X F 95 Director 058-05-6803 Usual Residence of Decedent 28a-f show 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Potomac Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 U.S.A. 8919 Liberty Lane within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White Completed 3 X Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Secretary Law Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Solomon Werner Anna Goldbera permit. Page 1 and 2 should be Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3030 Piano Lane. Silver Spring. Maryland 20904 Laurie Dubrow - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or Garden of Remembrance 05/02/2011 | Clarksburg, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service M00709 any 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the psease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician Anemia, Gastrointestinal Blood Loss disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Debility Sequentially list conditions, Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events that the death certificate be executed Cardiovascular Disease Due to (or as a consequence of resulting in death) Last -burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No jo Month Day Year Pregnant at time of death the detached þ should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician; The law requires 1 ☐ Yes 2 🏖 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate Yes 2 X No 1 Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted 2 🛛 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify, ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 \square Pending hin 24 hours after death.

the Funeral Director: Aft

Tipleted filled in by the fur 1 🗌 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F To the unity untel Contifying Nurse Pranticator To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 2011 D35579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan J. Miller, M.D., 6844 Tulip Hill Terrace, Bethesda, Maryland 20816 31. Date filed (Month, Day, Year) 3. Registrar's Signa MAY 0 4 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar FH TCHD pha 5/10/11 . Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Month 4 Physician/ 7:40 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT HOSPICE HOUSE **EASTON** TALBOT 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Days Months Hours Min. 132-24-8064 88 JUNE 5, Year 922 Director UNKNOWN Usual Residence of Decedent 23a or 28a-f shov 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No TALBOT **EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 201 EAST DOVER STREET, APT. 1 21601 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE If Yes, Give 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) PERSONAL LIAISON FOR THE CHIEF OF NAVAL OPERATIONS Elementary/Seconday (0-12) U.S. DEPARTMENT College (1-4 or 5+) OF THE NAVY Be 17. Father's Name (First, Middle, Last)
CHRISTIAN BREIHOLZ 18. Mother's Name (First, Middle, Maiden Surname) BERTA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANE CANTER - OTHER Attorney 109 FEDERAL STREET, EASTON, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place) CHESAPEAKE CREMATION 5/6/2011 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL 200 SOUTH HARRISON STREET, EASTON, M HOME P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ta disease or condition Medical resulting in death) Examiner oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 2 No 1 🗌 Yes Yes 25. Was case referred to nedica Certificate: To Be 26. Place of Death (Check only one) examiner? 1 🔲 Yes 2 No Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE eral Director: After this filled in by the funeral dii 27. Manna of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b Signature License number 29d. Date signed (Month, Day, Year) 02 30. Name and address of person ause of death (Item 23a) (Type, Print) Grad 8221 Tea 31. Date filed egistrar's Signatu State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Teresa Jane Edmiston . 48 Mav 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Allegany Allegany Health Nursing & Rehab. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** (Month, Day, Year) 03/23/1928 Country) Maryland Months Hours 1 M 2 F 213-24-5858 83 Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 No MI Allegany Cumberland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 11500 Walnut Valley Lane 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2 X No Yes, Give 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Clerk Retail Be 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ೭ Irene Deremer Richard Greise Elsie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 180 Tiverton Drive, Hyndman, PA Kevin Yost / Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 🄀 Cremation 3 ☐ Removal from State Cumberland Crematory 05/06/2011 Cumberland, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, of Funeral SerNic 21502 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Pnysician Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examine Due to (or as a consequence of): cause. Enter Underlying use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): led by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE: , outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months Month Day Year Pregnant at time of death 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 1 Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Tyes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funera Natural (Month, Day, Year) injury work?
1 Yes 2 No 5 🗌 Pending M Investigation 2 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Ceptifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Fractioner: To the best of my throwledge teta end dens, end dus ordy one Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

NAY 0 6 State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ May 10:44 AM 2011 3 Farrell Margaret Marv Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Wittman Talbot 22629 Pot Pie Road 9. Birthplace (State or Foreign 1 Year If Under 24 Hrs 8. Date of Birth If Under 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1-30-1921 Countre Pa. 1 M 2 X 90 048-09-9054 Yrs Director Usual Residence of Decedent 10d. Inside City Limits or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Md. Talbot Wi t tman 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. Funeral 21676 22629 Pot Pie Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 No If Yes, Give Year or Dates. 14. Race - American Indian, 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 XWidowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than " Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha Public Service Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stratton Bessie ပ Clark Leo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3016 Sounding Drive, Edgewood, Md. 21040 Joseph M. Farrell/ Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 a
Department of H
Important: If ite
any injury or oth cemetery, crematory or other place)

Crem. of Delmarva 1 Burial 2 X Cremation 3 Removal from State 5-5-2011 Delmar, De. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Hurtev Ado Ostrowski Funeral Home P.A. Defreswik, Joseph M P.O. Box 518 St. Michaels, Md. 21663 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying signed by the attending physician and be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events o (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ Month in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should peen Non Insulin Requiring Deathetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 certificate has page 2 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Granddaughter: Home Hospital: Other: 4 Nursing Home 5 Residence Other (Spec 1 ☐ Yes 2 ☑ No မြ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: After ✓ Natural work' 5 Pending 1 🗌 Yes 2 🗌 No 24 hours after death. Funeral Director: A Investigation Accident upleted filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Mussell a Silver & HU5587 05-05-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Easton MA Schiller 555 Cynword by 31. Date filed (Month State MAY 05 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 27 2011 Year Physician/ **FAIRBANK** PRESTON J. 6:50 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Talbot Easton Genesis Health Care The Pines **Funeral** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Country) Md. 218-07-5316 4°21°21°919 Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified Yes 2 No Md. Talbot Easton 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 21601 U.S.A. 610 Dutchmans Lane filed within 72 hours after death valledeath valledeath vallede. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give "natural", or iterr ledical Examiner n 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced Completed Army Year or Dates Preston Fairbank 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Plant Manager Food Processing 10 -0-Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thrent of Health and Mental rant: If item 27 is marked or ൧ Mary Marshall Millard Department of Health and Ment Important: If Item 27 is marker any injury or other traumatic e Fairbank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21100 Tanyard Road, Preston, Md. 21655 Samuel J. Fairbank / 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Neavitt Cemetery 5 - 2 - 2011Neavitt. Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Hardevo & Ostrowski Funeral Home P.A. Joseph m P.O. Box 518 St. Michaels, Md. 21663)stiziwsk C.F.S 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on e. ch line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner KAN Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine that initiated events resulting in death) Last burialattending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Year signed by the a d be detached f 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, To the Hospital or Attending Priysican. Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

AV+P

DHMH 17 Rev 7/2009

State Registrar

3 🗌 29b. Signature and title of certifier

29d. Date signed (Month. Day, Year

mons Ln Easton MD 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lena Alice Foltz May 2011 4:20 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 45330 Stark Drive St. Mary's Piney Point If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, September 26. 1 M 2 X F Months Hours Min 90 Yrs. **Director** 579-18-9121 Maryland Usual Residence of Decedent shov 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No Piney Point <u>Maryland</u> St. Mary's with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 45330 Stark Drive 20674 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" 3 ☒ Widowed 4 ☐ Divorced White event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other that Manager Apartment Complexes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ or other traumatic Dorie Cleveland Lear, Sr. Mildred Junkins and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health <u>Linda Russell / Daughter</u> 18635 Denton Road, Valley Lee, MD 20692 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) 2011 Charles Memorial Gardens Leonardtown, Maryland Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 Signature of Furgeral Service Liconsee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death ubmandibular alanc Physician/ 0 CCINDMA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 mopths? Month Day Pregnant at time of death Year 1 Yes 2 No be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ovonar 1 ☐ Yes 2 ☐ No 3 ☐ Probably ❤️ Unknown Completed iis certificate has been si director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of pidemip 24a. Was an after death.

Director: After this certificate ulmonar 1 Yes 2 No Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 1 Natural 28d. Describe how injury occurred the Hospital or Attending 5 Pending injury Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year, 60210

DHMH 17 Rev 7/2009

State Registrar Amsh

Three Notch

20636

MID

Hollywood

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

24035

Shah, MD

31. Date filed (Month, Day, Year) **MAY 0 9 2011**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 20^{Year} 6:30 aM Raymond David FELTNER, May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 9711 June Avenue Washington Hagerstown 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Months July 30 1 X M 2 D F West Va. **Director** 59 217-56-1351 Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Hagerstown Maryland Washington 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be Funeral 23a USA 9711 June Avenue permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No N. Guard
If Yes, Give Black White etc ō Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Specify: White 3 Widowed 4 Divorced Year or Dates. 1970 marked other than "natumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Manufacturing Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Shirley Viola Jackson Raymond David Feltner id 2 of Health an on 27 is mo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9711 June Avenue, Hagerstown, Maryland 21740 Marlene Feltner - Wife Department of Health Important: If item 27 any injury or other ti 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 5/10/2011 Hagerstown, Maryland Rose Hill Cemetery Signatu - Tuneral Service Lice 22. Name and Address of Facility MINNICH FUNERAL HOME E. Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Immediate Cause (Final Onset and Deat Ph. sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury use as the bunial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Pregnant 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown as been signed by the should be detached fonditions contribution to death but not resulting in the underlying cause given in Part I. Part II. Other significant 23e. Did tobacco use contribute to the cause of death? New our 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy performe prior to completion of cause of death? page 2 Yes 25. Was case referred to m → cal examiner? 1 ☐ Yes 2 ☐ No Be 26 Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify Hospital P 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) ပ္ address of person who completed cause of death (Item 23a) (Type, Print) MILL ST, HAGERSTOWN 25H10+1 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Garland Fleischhauer 2011 4:15 P M May Medical 4c. County of Death Allegany 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cumberland Golden Living Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) 06/11/1916 Days 1 X M 2 D F Min. 94 **Director** 214-05-4883 Virginia Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 510 Talbot Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S.P.S. Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Stark Fleischhauer William Henry Martha Jane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean L. Schramm /Daughter 19913 Westerly Avenue, Poolesville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Mem. Park | 05/09/2011 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, Sign Ture of Funeral Service 404 Decatur Street, Cumberland, MD 0.6 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Coronn disease or condition Medical resulting in death) Due to (or as a const quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last -tran Due to (or as a consequence of) burial-Physician/Medical Division of Vital Records, P.O. Box 68760 the be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 No ☐ Yes To Be 25. Was case referred to medica completed filled in by the funeral director, 26. Place of Death (Check only one) 2 No Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 D Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1-X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month. Dav. Year) 00033280 2011 May 6

Registrar

DHMH 17 Rev 7/2009

625 Kent Avenue, Cumberland, MD

21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Sunil K. Gupta, M.D.,

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month April Day Physician/ Alvin 28. 2011 1:50P M Riley Funk Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Olney Montgomery General Hospital Montgomery Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 ∏ F Days Min Year) 579-26-5897 83 1928 Washington D.C. **Director** Usual Residence of Decedent show 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Frederick Walkersville 10e. Street and Number 10g. Citizen of What Country? Funeral 21793 U.S.A. 133 Albany Avenue East 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 XWidowed 4 Divorced Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Sales Manager Whirlpool Appliances 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ should be Jonathin Alice W. (Unknown) Η. Funk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Scott B. Ruete - Executor 24409 Galeano Way, Damascus, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \square Burial 2 \nearrow Cremation 3 \square Removal from State 4 \square Conation 5 \square Other (Specify) Metropolitan Crematorium 5/2/201 Alexandria, Virginia 22. Name and Address of Facility Molesworth—Williams P.A., Funeral Home 21. Signature of Funeral Service Licensee 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ entrice disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Oumon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami Pulmonary Edema attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? Month Day signed by the at d be detached fo 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? in 24 hours after death.

The Funeral Director: After this certificate in pleted filled in by the funeral director, page 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☑ No ဂ္ဂ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. work?
1 Yes 2 No 1 Matural injury 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one 29b. Signature d title of certifier 29d. Date signed (Month, Day, Year)

5+ IVA State Registrar Drive

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

be, uce

31. Date filed (Month, Day, Year)

philip

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PADMAJA

2011

4/29

, Maryland - 2083 Z

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 349 AM Hattie Viola Grim Mey Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Washington Sharpsburg 3613 Harpers Ferry Rd. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sept. D26 ea 1930 Months Hours "Maryland 80 Director <u> 214-28**-**0547</u> Usual Residence of Decedent 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland Washington Sharpsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21782 2411 Dargan Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or itel idical Examiner Black, White, etc. þ 1 Never Married 2 Married Yes 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. Completed Specify: 3 X Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Server Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever ၉ Mary Florence Jamison George Perry Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce A. Edwards-Daughter 3613 Harpers Ferry Rd. Sharpsburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō Department of Important: If it any injury or conce. 1XXBurial 2 Cremation 3 Rem 4 Donation 5 Other (Specific Samples Manor Cemetery May 10,2011 Sharpsburg, Maryland nature of Funeral Se Osborne Adlanerally Home, P.A. 21795 425 S. Conococheague St.Williamsport,MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 100 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Dust to (or es a nonsequence of): Exami attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the at d be detached for 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed Yes 2 No 1 Tyes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Daughter home examiner? ٥ 1 Yes 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specific 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 7 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gibson Judith Ann Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 10819 Gibson Lane Allegany Cumberland 5. Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Birthpiac (Country) MD Dec 27 1 M 2 D Hours Min. Director 219-44-0976 65 Usual Residence of Decedent 28a-f show 10a. State 10b. County event, the M-dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Cumberland Allegany 1 □xYes 2 □ No 10e, Street and Number 10f. Zip Code 9 10g. Citizen of What Country? Funeral with 23a 10819 Gibson Lane 21502 USA items ? hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black White etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify "natural" Completed 3 Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) and Mental Hygiene. homemaker own home is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dorothy (Long) Ringler Roy Ringler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10819 Gibson Lane Cumberland MD 21502 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Robert Gibson husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 5 1 Burial 2 Kremation 3 Removal from State Scarpelli Funeral Home, P.A. 5/2/2011 MD Cresaptown injury 4 Donation 5 Other (Specify) ignature of Funeral Service U 22. Name and Address of Facility eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part / Enter the disease, or complications at clused the death. Do not shock, or heart failure. List only one causi on each line. enter the floode of dving, such as cardiac or respiratory arrest Immediate Cause (Final and D Physician. disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or finjury use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) for Month Day Year Pregnant at time of death Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown g 🗌 Unknown vare nas been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 2 1 No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural injury work? 5 Pending 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical C ing 'hysician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

dical aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the only on 29b. Signatur 29d. Date signed (Month. Day, Year) 21604 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENT AVE. STE. 309 0 6 201 32. Registrar's Signature State Registrar

		1 - For State Registrar	State of M		Depa	rtment of H	ealth an		ental Hygi	111	6135	
Physici:		1. Decedent's Name (First, Middle	, Last) Othy Ann Gri	iffin					2. Date of Death Month May	3, 2011	3. Time of Death 3:05 p M	
Examin		4a. Facility Name (If not institution Harford Men	give street and number)			4b. City, Town, or Havr	Location of D		e	4c. County of D	eath arford	
Funeral Director		5. Social Security Number 215–34–5492	6. Sex 7. Ag	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. Min.	8. Date of Birth (Month, Day, Oct. 14,	^{Year)} 1936 Ma	Birthplace (State or Foreign Country) ryland		
aryland show	o	Usual Residence of Decedent 10a. State 10b. County Maryland Ce	ecil	10c. City, To		cation Port Depo	sit				10d. Inside City Limits 1 ★Yes 2 No	
ath with the Marylan 23a or 28a-f show	I Direct	10e. Street and Number 56 Old School I		1		10f. Zip Code	21904		10	g. Citizen of What		
s after death ; or items 2; eminer mus	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marri 3 ☒ Widowed 4 □ Divorced	If Yes, Give	,		∐ Was Decedent of Hi fYes, specify Cuba I □Yes ধ No	spanic Origin n, Mexican, P Specify:	n? (Spe Puerto F	ecify Yes or No- Rican, etc.)		merican Indian,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed t	15. Decedent (Specify only highes Elementary/Secondary (0-12)	Year or Dates: S Education t grade completed) College (1-4or		(Give life. l	dent's Usual Occupi kind of work done of DO NOT use retired Food Serv	luring most of)	f workir		6b. Kind of Busine Bainbridg Trainir	ng Center	
ld be filed w ental Hygie ked other t ic event, in	To Be Co	Twelve Years 17. Father's Name (First, Middle, L Dewey			rood serv		Bainbridge, Maryland aiden Surname) nomas					
nd 2 shoul alth and M 27 is mar er traumati	F	19a. Informant's Name/Relationsh Antoine Griffin		1	9b. Mailir 00 I	ng Address <i>(Street a</i> nn Keeper	and Number of Court	or Rura E, E	al Route Number, Elkton,	City or Town, Stat Maryland	e, Zip Code) 21921	
Pages 1 a nent of He int: If item iry or othe		20a. Method of Disposition 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery, crematory or other place) 20b. Place of Disposition (Name of cemptery,										
permit. Departn Importa any inju		21. Signature of Funeral Service Licensee Licensee Licensee Lee A. Patterson & Son Funeral Home. P.A. Perryville, Maryland 21903-0766										
Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BACTEREMIA Due to (or as a consequence of):									Approximate Interval Between Onset and Death	
ecnted yuq	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undert in. Cause (Disease or injury that initiated events	c	a consequenc					≥5 day			
cate be ex ohysician a the burial-		resulting in death) Last	e of):									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		☐ Ectopic pregnance ☐ Other <i>(specify)</i>	/		23d. Date of delivery Month Day Year					
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or Attending Phys after death. Director: After this I in by the funeral dii		27. Manner of Death 11 Natural 5 ☐ Pending 2 ☐ Accident investig	ation		o. Time of Injury	Work	yat :? Yes 2 ⊡No		28d. Describe ho	w injury occurred		
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To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	g Physician: To the best Examiner: On the basis and manner s	of examination	lge, deat and/or in	h occurred at the tir vestigation, in my o	ne, date and pinion, death	place, occurr	and due to the cared at the time, da	ause(s) and manne ate and place, and	er as stated. due to the cause(s)	
Withi To th	Ĭ	29b. Signature and title of certifier				29c. Licens	e number		25	9d. Date signed (M	fonth, Day, Year)	

Medical Doctor

D71096

29d. Date signed (Month, Day, Year) May 3,2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

501 S. Union Are. House De Grace MO 21018 ANGELIM ESMOILLA

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature pare

HAROFOEDT.

Baltimore, Maryland 21215-0036

ムル P.P. J. DOハの丁ガソ DOG; Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gordon Elizabeth Ann Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland WMHS-RMC If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 □ F Min. Apr 11, 1945 Director 556-37-1207 66 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Allegany Cumberland MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 21502 USA 435 Pennsylvania Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? 1 Never Married 2 Married Completed by 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced If Yes, Give white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Rhea Margaretta (Weimer) Lepley Rev. Albert L. Lepley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 4603 35th Street San Diego 92116 George Gordon son item 27 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it Scarpelli Funeral Home, P.A. 1 Burial 2 Kremation 3 Removal from State 5/12/2011 MD Cresaptown 4 Demation 5 Other (Specify) 21. Signature of Funeral Service Lig 22. Name and Address of Facilitieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Traumati disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Al Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir sician and burial-transit Cause (Disease or iinjury that initiated events that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Box 68760 attending p IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death Yes 2 No signed by the a 1 Yes 2 Unknown 9 \ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate ha Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be examiner?

1 Yes 2 No 26. Place of Death (Check only one) မ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: ☐ Natural 5 Pending iniury work? FE(s after death.

I Director: Aft in by the fur 2035 2 No 2 Accident 3 Suicide Investigation Could not be ce of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined ing, etc 433 PENN AVE CUMBERLAM €510 ENE € Medical 29a. Certifier Certifyin To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. miner: On the bass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

ursp Practioner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical 3 Certifyin only one 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 29c. License number 5/11 10 105M cause of death (Item 23a) (Type, Print) 30. Name and address of person who complet 125021 SILLOUPROOK 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 9:08 PM <u>Lois Ann Hofman</u> Mav 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Denton Caroline Caroline Hospice Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 ▼□ F Hours July 28, 1928 Director 82 Wisconsin <u>396-24-4871</u> Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Caroline Denton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8266 Laurel Lane 21629 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💟 No Specify þ Specify: 3 Widowed 4 ☐ Divorced White "natural", Completed d other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Family Ith and Mental Hygier
77 is marked other the 12 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elmer George Hahn 2 Loretta Catherine Conrad 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Donna Weber/daughter 8266 Laurel Lane Denton, Maryland 21629 permit. Pages 1 and :
Department of Health
Important: If item 27
any injury or other tr
once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Florida National Cemetery | May 20,2011 | Bushnell, Florida ne of Funeral Service Licenses 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street Denton, Maryland 21629 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final THRIVE FAILURE **Physician** TO disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner HEART FAILURE DIASTOLIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, CKD Physician/Medical attending p IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 mon Month Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has l irector, page 2 s autopsy performed? 2 No 1 ☐ Yes 2 No 1∏Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Souther (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 7 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ,10,2011 MD D0068045

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

DAFFIN LANE, DENTON MD 21629

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD, 609

32. Registrar's Signature

KAVITA MOHAN

31. Date filed (Month, Day, Year)

AS I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death TCHD. FH2 pha 5/5/11 Registrar Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Medical aron 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Memoria Easton Talbo 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 8. Date of Birth 1 M 2 X F Months Hours Min (Month, Day, Y Maryland Director Yrs 214-60-767 59 Usual Residence of Decedent show 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Md. 1 🗌 Yes 2 🕅 No Kent Chestertown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1810 Pondtown Road 21620 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc þ 1 X Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Black Completed 3 - Widowed 4 - Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Manor al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper Chester River Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of permit. Page 1 and 2 should be.
Department of Health and Mental Important; if item 27 is meany injury or other မ Romie Edward Elsie Mae Elliott Hynson, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Marvin Winchester, Jr 1810 PondtownRd. Chestertown, Md. 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 05-14-11 | Pondtown, Md. Bordley Chapel 4. Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 855 High Street, Chestertown, Md. 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final pertensive Ph_sician/ disease or condition resulting in death) Medical (or as a consequence of): **Examiner** 020 Sequentially list conditions, Due to (or as a consequence of) il any, leading to inmediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burlal-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 Other: မ 1 Yes 1 Depatient 2 ER/Outpatient 3 DOA After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: A

mpleted filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29c. License number 00053 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington St. De NLD. 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death MAY 8, 2011 Physician/ 9:15 A M OREN EDWARD HOPKINS, JR. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT **EASTON** 28928 JASPER LANE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** VIRGINIA Days 1 **X** M 2 □ F Months Hours Min. 2/12/1925 86 224-20-9556 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County with the Maryland 10a. State Director must be notified 1 X Yes 2 No 28a-f MD TALBOT **EASTON** 10g. Citizen of What Country? 10f. Zip Code 0 10e, Street and Numbe Funeral 23a 28928 JASPER LANE 21601 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 12. Was Decedent Ever in U.S. ral", or iten 11. Marital Status Armed Forces?

1 X Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working WASTE WATER life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) MANAGEMENT INDUSTRIAL ENGINEER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည NORMA BROCK OREN EDWARD HOPKINS, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARIAN B. HOPKINS, WIFE 28928 JASPER LANE, EASTON, MD 21601 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 5 1 Burial 2 X Cremation 3 Removal from State 5/10/2011 CHESAPEAKE CREMATION STEVENSVILLE, MD 4 Donation 5 Other (Specify) Name and Address of Facilit STREET, EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter Approximate Interval Between shock, or heart failure. List only one cause on each line ye an Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months? Year Month Day Pregnant at time of death 5 Other (specify) signed by the a d be detached f Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes been sign Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 ☐ No certificate 2 N N ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) la B examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 24 hours after deat Funeral Director: Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29d. Date signed (Month, Day, Year) 29c. License number

12+VA

CAROLYN HELMLY

31. Date filed (Month, Day, Year)

NAY 10 2011

30. Name and address of person who completed cause of Gath (Item 23a) (Type, Print)

508 IDLEWILD AVENUE, EASTON, MD

State Registrar 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **MAY** Physician/ 10° DOROTHY LEE HARRINGTON 2011 2:45 \mathbf{A}^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT EASTON TALBOT HOSPICE HOUSE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Months Days Hours Min 03/31/1933 Director 78 MARYLAND 220-28-2095 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits notified at 10c. City, Town or Location Director 1 Yes 2 No PRESTON MD CAROLINE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ö ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral UNITED STATES 21655 21554 TANYARD ROAD hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗶 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 K Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME 12 HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ESTELLA BLANCHE ANDREWS JAMES MADISON TOWERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21554 TANYARD ROAD, PRESTON, MD 21655 JAMES P. HARRINGTON / HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date WOODLAWN MEMORIAL PARK 1 X Burial 2 Cremation 3 Removal from State 05/14/2011 EASTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. lanna 200 SOUTH HARRISON ST., EASTON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Enysician** MA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of injury Due to (or as a consequence of) Examin ysician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregn 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No for Dav Pregnant at time of death the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 1 Tyes been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to redical examiner?

1 Yes 2 No director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE မ 1 Inpatient 2 ER/Outpatient 3 DOA this s after death.

I Director: After this d in by the funeral d 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined hin 24 hours af the Funeral Di npleted filled ir Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within 2 To the I 29b. Signature and title of 29d. Date signed (Month, Day, Year) 0/1 ess of person who completed cause of death (Item 23a) (Type, Print) 555 CYNWOOD DR., EASTON, MD KATHRYN D. HELSABECK, MD 21601 mth, Day, Year)
MAY 11 2011 31. Date filed (Month State Registrar

Ext.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death Month 04 I. Decedent's Name (First, Middle, Last) 3. Time of Death Day 30 Year 11 Physician/ Dona 1 d Raymond Harner 10:18A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Bowie 3111 Shield Lane If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month D Months Days 1 **X** M 2 □ F Hours Min 74 577-52-4092 Washington, D.C. Director lan Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State the Maryland Funeral Director ams 23a or 28a-f sh r must be notified a Bowie 1 X Yes 2 No Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with U. S. A. 20715 3111 Shield Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status r than "natural", or iter the Medical Examiner Armed Forces? Black White etc. ģ 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White "natural", 3 Divorced 4 Divorced Completed U. S. Government 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene. Fitem 27 is marked other than other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Printing Office Book Binder Be 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) ပ Catherine Marie Eyler John Howard Harner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3111 Shield Lane. Bowie. Maryland 20715 19a. Informant's Name/Relationship (Type, Print) Department of Health al Important: If item 27 is any injury or other trau 3111 Shield Lane, Bowie, Maryland Ann M. Harner/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Huntt Crematory 5/1/2011 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home, Signature of Funeral Service kicensee Al- /-Kon 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ lasta disease or condition resulting in death) Medical Due to (or as] consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.
Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 5 Other (specify) signed by the at d be detached for g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy 1 Yes 2 🗆 No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 3306 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical Parkway STA210

DHMH 17 Rev 7/2009

Registrar

Date filed (Month, Day,

MAY 0 4 2011

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John William Hunt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Western Maryland Regional Medical Center Cumberland Allegany If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Country) Maryland (Month, Day, Year) January 15, 1928 1 M 2 🗆 Months Days Hours 212-24-0968 Director 83 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location death with the Maryland the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland Allegany Midland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 14932 Paradise Street 21542 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 within 72 hours after 1 Tes 2 No If Yes, Give Year or Dates should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Minister 12 0 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Vance Hunt Mary Tighe permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Hunt - Son 11106 Upper Georges Creek Road, Frostburg, Maryland, 21532 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date May 05, 13 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) rostburg Memorial Park Frostburg, Maryland 2011 Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 rond 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HURACIC disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a nonsequence of) physician and the bunal-transit that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b þ or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No certificate Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Pppatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director. After thi
completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011 02690 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nds Cumberland Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 2, Physician/ 201^a1 Clifton Joseph Hill, Sr. 10:00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death College View Center Frederick Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Year 19<u>34</u> 1 🖾 M 2 ☐ F Oct. Io, 577-44-3255 76 Maryland Director Yrs. Usual Residence of Decedent 28a-f show with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified 1 Yes 2 X No Maryland Montgomery Clarksburg ō 10e. Street and Numbe items 23a or ner must be n 10g. Citizen of What Country? Funeral 15015 Hyattstown Mill Road 20871 United States death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Medical Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) t t Business Owner Excavation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Leslie Ray Hill Catherine Mary Lowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health as
Important: If item 27 is
any injury or other trau Tammy Griffith / Daughter 15015 Hyattstown Mill Rd. Clarksburg, MD 20871 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Resthaven
Memorial Gardens 1 X Burial 2 Cremation 3 Removal from State May 6, 2011 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Frieral Service Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin mountain Hwy. Frederick, MD 21701 23a. Part 1. Enter the diseas shock, or heart failure. I or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate List only one cause on each line Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ardiamyo Medical Due to (or as a conseque ce of). **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examir Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician are the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 as t attending p use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Renal Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performed certificate 1 Yes 2 No After this certification of the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 10 1 🗌 Yes Other: မ Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis or examination arror investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 560417 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tohnson Dr. 10 Shah Thomas 32. Revistrar's Signature State

Registrar

eneur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 2011 6:48 PM REGINA ELIZABETH HARLEY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. **Funeral** Sex Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🌁 Days Hours 220-26-6790 August 3, 1930 80 **Director** Yrs Maryland Usual Residence of Decedent show 10b. County filed within 72 hours after death with the Maryland 10a. State other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick or 28a-f Thurmont. 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral or items 23a 12A Stull Drive 21788 United States of America 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🛣 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", White 3 Nidowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress 6 Textiles Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o 2 Willis R. Devilbiss Edna Grace Geesey 19a Informant's Name/Relationship (Type, Print)
Linda L. Clay Daughter 11624 Gladenilli Brothers Road, Monrovia, Maryland 21770 Eugene William Harley, Jr. 20151 Senic View Court, Boonsboro, Maryland 21713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Resthaven Memorial Gardens | May 6, 2011 Frederick, Maryland Signature of Funeral Service Licensee Name and Address of Facility
Keeney & Basford P.A. Funeral Home
106 East Church Street, Frederick, Maryland 21701 Ver 0 M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) rece) C Medical Due to (or as a **Examiner** cut-e Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine **To the Hospital or Attending Physician:** The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Dav Year 4 Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury within 24 hours and to to the Funeral Director: After To the Funeral Director: After To the full to th Investigation Could not be 2 No Accident 1 Yes Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a 29c. License number 30. Name and address of 🍂 rson was completed cause g death (Item 23a) (Type, Print) HGARUNO LEV 32. Re strar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12^{Day} Mar 2011 Laurabelle Deputy Hubbs 1450 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital E1kton Cecil Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F Months Days Hours JAN 4. 1936 Maryland **Director** 221-22-9693 75 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Tyes 2 No Marvland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a or ner must be n Funeral 16 Shelter Cove Road 21901 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 - Widowed 4 X Divorced White 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene.

item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker In Her Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willard N. Deputy, Sr. Mildred Saunders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven P. Hubbs/Son 16 Shelter Cove Road, North East, MD t of Healt : If item ' / or other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) R. A. Ferris & Co., Inc. West Chester, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, F.A. 103 W. Stockton Street, Elkton, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical to (or as a consequence of) Examiner Sequentially list conditions Examine ir any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transil Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atte page 2 should be detached for Month Year 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 25. Was case referred to medica 26. Place of Death (Check only one) 2 No Other: 1 Yes Inpatient 2 DER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1, 🖳 Natural 5 Pending work? Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m 23a) (Type, Print) 30. Name and address of person who compl Barbara A. Parey,

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 15^{ay} Month May ,2011 Physician/ Hazel Irene Harbaugh 12:47P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Meritus Medical Center Washington **Hagers** town Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year . Social Security Number 7. Age (In yrs. last birthday) Funeral Days Months Hours 1 🗆 M 2 🗔 79 Director 172-26-9757 1932 <u>Pennsvlvania</u> nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland bartment of Health and Mental Hygiene. And Antarti: If item 27 is marked other than "natural", or items 23a or 28a-f show forthart: If item 27 is marked other than "natural", or items 25a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director Cascade Md. Washington 1 ☐ Yes 2 🔽 No 10f. Zip Code 10g, Citizen of What Country? 10e, Street and Number Funeral U.S.A 21719 25251 Cascade Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ella Newcomer 2 Ira Fahrney 19b Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 25251 Cascade Rd. Cascade, Md. 21719 19a. Informant's Name/Relationship (Type, Print)
Arben A. Harbaugh (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 17, 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Md. Smithsburg Crematory 22. Name and Address of Facility 21. Signature of Funeral Service License 12525 Bradbury Ave. M01414 J.L. Davis Funeral Home Smithsburg.Md.21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. 2 M N Th Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a of nsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an autops prior to completion of cause of death? Be (26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 1 Yes Inpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ≥ Certifying P sicia: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical aminer On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse, ractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a who completed cause of death (Item 23a) (Type, Print IM MYChup 22911 1. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Day 201 Physician/ Haynes Jackson Dorothy Jean Medical Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 100mico 8. Date of Birth (Month, Day, Yea Apr. 15, If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 6. Sex . Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Maryland 217-54-6124 60 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a, State 10c. City, Town or Location Director Federalsburg Caroline MD 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or any njury or other traumatic event, the Medical Examiner must be a once. 21632 Funeral 111A Davis Lane United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker 12 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ella Louise Haynes Harding R. Prattis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 East Pine St., Delmar, MD 21875 Kevin Jackson/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fastern Sh. Veterans Cem. 05/11/11 20a. Method of Disposition 20c. Location - City or Town, State Hurlock, Maryland 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARCINOMA UNKNOWN Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of for use as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 5 Other (specify) s been signed by the same should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has ; page 2 autopsy performe Hospital or Attending Physician: The I 24 hours after death. Funeral Director, After this certificate h sted filled in by the funeral director, page 1 Yes 2 Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work' 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aft

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 🖵 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

29d. Date signed (Month, Day, Year)

SALISIBLE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month D2011 Physician/ 7, 4:05 P May Thomas Louis Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince George Clinton Southern Maryland Hospital 8. Date of Birth (Month, Day Yea Mar. 24, 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Min. Hours 1**X** M 2 □ F Maryland 1957 **Director** 217-76-4418 54 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland must be notified at Director 1 Yes 2 No California Maryland St. Mary's 10g. Citizen of What Country? 10f. Zip Code 0 10e. Street and Number "natural", or items 23a Funeral U.S.A. 20619 22477 Cornwall Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1

Never Married 2

Married þ Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2X No Specify: 3 Widowed 4 Divorced Completed of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waste Management Sanitary Worker 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Bernice Bennett Rudolph Jerdon Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shment of Health a tant: If item 27 i 22477 Cornwall Dr., California, MD 20619 Agnes Rose Jerdon / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 0 = 10 1 XBurial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Lexington Park, MD 4 Donation 5 Other (Specify) 5-17-2011 Immaculate Heart 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood RD., Leonardtown, MD 20650 Danielle N. Ward M01403 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner organitary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a conseque Physician/Medical Division of Vital Records, P.O. Box 68760 /es, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month been signed by the atte should be detached for Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificate has the lirector, page 2 s autopsy performed? Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 1 **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 20c License number

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAY 1 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Jackson Laura 2335 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HICOMICO TENINSULA SALISBURG MICAL 5. Social Security Number If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country). . Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F Hours (Month, Day, Year) 02/10/195] 213-60-9258 Director 60 Georgia Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 222 Clover Street 21804 within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married <u>و</u> Maryland 21215-0036 1 Yes 2 X No Specify: Black 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Poultry Production Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Eulie Jackson Lelia Young other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zir. 535 N. Curlew Rd., Salisbury, MD 21801 19a. Informant's Name/Relationship (Type, Print) Vaughn Parker/son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State injury or 4 Donation 5 Other (Specify) 5/4/2011 Salisbury, MD Salisbury Crematory 21. Signature of Funeral Service 22. Name and Address of Facility
HOLLOWAY Funeral Home Professional Association any WillR 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence or). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) as been signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law autopsy performed Yes 2 page After this certificate 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? (Month, Day, Year) Natural 5 Pending nours after death. neral Director: Aff If filled in by the fur 1 Yes 2 No 2 Accident Investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours af
To the Funeral D
completed filled in Medical 29a. Certifier 1 🗌 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 In the lical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. The Contitying Nurse Practice are the line with the cause of the line of of the li 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) H. Z6. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. CARDII 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>011</u> Physician/ April Enid Aurora Kernahan 30 7:24 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bowie Health Care Center Bowie Prince George's If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year 1917 1 □ M 2**X X**F Months Hours Days Director 056-18-8784 93 Trinidad Usual Residence of Decedent ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? Funeral 6701 Homestake Drive 20720 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 💢 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: 3XXWidowed 4 □ Divorced Specify: Completed **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+ Nurse's Aid Health Care marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Gill Maude Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Deborah Kernahan/Daughter 6701 Homestake Drive, Bowie, MD 20720 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State Baltimore-Washington 05/04/2011 4 Donation 5 Other (Specify) |Laurel, Maryland 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licenses 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of): law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? Completed by Dementia Records, 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No Hospital or Attending Physician: The 1 Yes 2 X No 25. Was case referred to medical Division of Vital æ 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Yes 읻 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural injury 5 Pending after death. Director: Af 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D45217 05/02/2011 30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

CA+4 State

Registrar
DHMH 17 Rev 7/2009

Suite M18, Berwyn Heights, MD 20740

Ajayi, 6201 Greenbelt Rd.,

31. Date filed (Month, Day, Year) **MAY 0 4 2011**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mont4/30/2011 Richard Mitchell Kanter 748am м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Annapolitan Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral ★** M 2 □ F Months Hours Min **Director** 231-14-4865 88 Usual Residence of Decedent 28a-f show 10b. County 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2x No Howard Ellicott City 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 2404 Hannon Court 21042 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces

1 K Yes 2 I

If Yes, Give Black, White, etc. 2 □ No WWII 1 Never Married 2 KM Arried þ Baltimore, Maryland 21215-0036 1 Yes 2KNo Specify: White 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) Attorney Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emanuel Kanter Jennie Copeland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Kanter 2404 Hannon CT. Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) injury or 5/15/2011 | Annapolis, MD Hillcrest Memorial Signature of Funeral Service Citers 22. Name and Address of Facility Hardesty Funeral Home, P.A. Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transit Cause (Disease or limitary that initiated events and resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as 1 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 5 Other (specify) Pregnant at time of death 2 No detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autonsv performed? death?
1 Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner?
1 Yes 2X No 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

ABRAHAM

29c. License number

D56658

21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death KOBERTS Month Physician/ ZQII 6:06AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** E Rehab ALLEGANY AlleganyCounty Nursing Cumberland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖼 F (Month, Day, 212-12-8962 Min Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ELLERSLIE ALLEGANY 1 X Yes 2 No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9 ral", or items 23a o Examiner must be Funeral 21529 Ellerslie USA 4412 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Hospital seam stress permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other tany injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Koberts ပ္ Sarah unknown UNKNOWA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellerslie RD POBOX 355 Ellerslie MO 21529 Gran DEH Patricia Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🏿 Cremation 3 🗷 Removal from State Cumberland Cure 4-30-11 4 M Donation 5 ☐ Other (Specify) Med 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HARVEY H. ZEIGLER Funeral Home INC 169 Clarence ST HUNDMAN PA 15545 23a. Part / Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Onset and Death Physician/ 090 disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 2 Unknown 4 ☐ Pregnam
9 ☐ Unknown sate has been signed by the page 2 should be detached Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No s after death.

I Director: After this certifical ed in by the funeral director, p the Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 1 P Natural iniury 5 Pending 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OR REBUSTEAND BARRERA 200 GLENNST. Suite 30% Cumberland MD 21502 32. Registrar's Signature State says

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Namina Kamara Apri Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Regional Laurel Hospital Laurel Prince George's 5. Social Security Number 7. Age (In yrs. last birthday, 1 Year If Under 24 Hrs. Days Hours Min. 9. Birthplace (State or Foreign Country) Sierra Leone **Funeral** 8. Date of Birth 1 □ M 2 🕱 F Months (Month, Day, Year) **Director** 579-35-9028 Usual Residence of Decedent should be filed within 72 hours are rand Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges Laurel Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3499 Fort Meade Rd. 20724 Sierra Leone Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the House Wife Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Abdul Kamara Mariam Sesay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, 20724 Zainab Kamara/Daughter 3499 Fort Meade Rd. LAurel, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National: 4/30/2011 Laurel, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home, 3831 Georgia Ave. NW Washington, DC cc0278 23a. Part 1. Enter the disease. Ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition Physician/ Myocardial Medical resulting in death) s a consequence of Examiner ertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of attending physician Physician/Medical Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ò Pregnant at time of death 5 Other (specify) Month Day Year ed by the detached 9 Unknown 9 Unknown P.O. signed ! Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Records, To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign expendent filled in by the funeral director, page 2 should be completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 1 2 No 1 Nes of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Natural iniury 5 Pending Division 2 Accident
3 Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who

MAY 04

31. Date filed (Month, Day, Year)

7300

MD

completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signatur

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

PAVS

Year

Day

1 TYes 2 No

06:25 P M

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

MAY & () 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Jean 3:40 p.mM Betty Lowery May 4 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Lexington Park Chesapeake Shores **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Hours 1 □ M 2 💢 F 03/10/1949 Washington, DC Director 214-76-2163 62 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland St. Mary' Lexington Park 10f. Zip Code 10g. Citizen of What Country? Funeral 21412 Great Mills Road 20653 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 **X** No Completed by 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Never Worked Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William J. Lowery Mary Jean Garnston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Dickerson/Personal 25470 Breton Marketplace, Leonardtown, MD 20650 Rep 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 ី Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 05/07/2011 | Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Small disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Lectopic pregna 5 Other (specify) Ectopic pregnancy Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Physician/ Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar

"natural", or items 23a or 28a-f show edical Examiner must be notified at

death v

illed within 72 hours after

Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur jury or other traumatic event, the Medical I

permit. Page 1 a
Department of H
Important: If ite
any injury or ot

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

Hospital or Attending Physician:

within 24 hours after death.

To the Funeral Director: After this certific
completed filled in by the funeral director,

Completed Be ᅆ Certificate:

Medical

page 2 s

autopsy performed? 1 🗆 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 5 Pending injury

Natural Accident Investigation M Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 14005575

30. Name and address derson who completed cause of death (Item 23a) (Type, Print)

20650 Schmidt, 40900 Merchants Lane, Suite 205, Leonardtown, MD D.O. Jennifer

State Registrar

examiner?

Manner of Death

2 X No

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month

Months

4b. City, Town, or Location of Death

If Under 24 Hrs.

Hours

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

California

Days

10f. Zip Code

20619

16a. Decedent's Usual Occupation

life. DO NOT use retired)

Property Manager

1 ☐ Yes 2 X No Specify:

(Give kind of work done during most of working

May

8. Date of Birth

10^(Month, Day, Year)

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

Country) Michigan

14. Race - American Indian,

White

Black, White, etc.

4c. County of Death

St. Mary's

10g. Citizen of What Country?

United States

Specify:

Housing

POINT LODKOUT Rd, LEONARDTOWN, MD-20650

16b. Kind of Business Industry

10:59 p.₩

Physician/ Medical **Examiner** For State Registrar

10a. State

Director

Funeral

Completed by

Rebecca

Social Security Number

524-27-8612

Usual Residence of Decedent

10e. Street and Number

11. Marital Status

Rose

4a. Facility Name (if not institution, give street and number)

10b. County

Decedent's Education

(Specify only highest grade completed)

23343 Dianthus Way

Maryland St. Mary's

23343 Dianthus Way

1 Never Married 2 X Married

3 Widowed 4 Divorced

Elementary/Seconday (0-12)

Lindberg

12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.

College (1-4 or 5+)

1 □ M 2 🗓 F

7. Age (In vrs. last birthday,

10c. City, Town or Location

California

45

Funeral Director ral", or items 23a or 28a-f show Examiner must be notified at "natural"

Page 1 and 2 should be filed within 72 hours after death with the Maryland permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical

Baltimore, Maryland 21215-0036

Pnysician/ Medical Examiner

the Hospital or Attending Physician: The law requires that the death certificate be executed aate has been signed by the attending physician and page 2 should be detached for use as the burial-transit this certificate completed filled in by the funeral director, within 24 hours after death. To the Funeral Director; After

Division of Vital Records, P.O. Box 68760

17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)									
욘	Richard Uno Johnson		Anita Elizabeth Hayes						
	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Add	ddress (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
	Derrik A. Lindberg/Husband	23343 Di	Dianthus Way, California, MD 20619						
	20a. Method of Disposition 20b 1 D Burial 2 X Cremation 3 D Removal from State	20b. Place of Disposition (Name of Date 20c. Location							
	4 Donation 5 Dother (Specify)	rlotte Ha	e Hall, MD						
	21. Similar of Teral Street Centre Edward N. Brinsfield, Jr. MO	neral Hom							
	23a. Part 1. Enter the disease, or complications that caused the de	mode of dying, such as cardi	5 Hollywood Road, Leonardtown, ode of dying, such as cardiac or respiratory arrest, hobbes tome multiforme						
	disease or condition resulting in death) a. Du to (or at a conse	equence of):	MOURES COME M	MINJOYME	<u>0</u>	Onset and Death yet mel o matts			
aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury								
dical Exa	that initiated events resulting in death) Last C. Due to (or as a conse	equence of):							
Completed by Physician/Medical Examiner	FFEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d.								
ed by Ph	Part II. Other significant conditions contributing to death but not	esulting in the underly	ving cause given in Part I.			ibute to the cause of death? 3 Probably 4 Unknown			
Complete		prior to cor death?	re autopsy findings available or to completion of cause of ath? Yes 2 □ No						
Be (25. Was case referred to medical examiner?		26. Place of Death (C	heck only one)					
မ	1 ☐ Yes 2 🗷 No Hospital: 1 ☐ Inpatient 2	ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing	ing Home 5 💢 Residence 6 🗌 Other (Specify)					
ficate:	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	28a. Date of injury (Month, Cay, Year) 28b. Time of injury 28c. Injury at work? 1							
l Certi	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At building, etc. (Spec	ury - At home, farm, street, factory, office 286			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Medical Certificate:	29a. Certifier (Check (Check only one) (Check one) (Check only one) (Check only one) (Check only one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (C	tion and/or investigatio	n, in my opinion, death occurre	ed at the time, date and pla	ace, and due to the cau	use(s) and manner stated.			
-	29b. Signature and title of certifier		29c. License number	29d.	d. Date signed (Month, Day, Year)				
	Jun 12 19.		068846		05/09/2011				

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Mont

HOSPITAL,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Yes 2 No

29b. Signature and title of certifier

Houl

27. Manner of Death

1 Natural

2 Accident

3 Suicide 4 Homicide

29a. Certifier (Check only one)

140

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

02

5 Pending investigation

6 Could not be determined

Date of Injury (Month, Day, Year)

Physician

/Medical

Director

Funeral

þ

Completed

Be

2

Examine

Physician/Medical

Completed by

Be

Medical Certification: To

Examiner

Funeral

Director

	State of M	arviand / Lia	partment of Health a	nd M	lental Hvair	ene.			
For State Registrar	State OF IVI	•	ertificate of Death			. No. 2	- Control of the Cont	16158	
. Decedent's Name (First, Middle,	Last)				Date of Death Month	Dav	Vaar	3. Time of Death	
Lesley	Lawr	ence			April 2	2, 2C) [Year	12:00 p ^M	
a. Facility Name (If not institution,	give street and number)		4b. City, Town, or Location of	Death		4c. Count	y of Deat	h	
305 E. Joppa R	d. APT 110	6	Towson			Balt	imor	e	
	6. Sex 7. Ag	e (In yrs. last birthda		4 Hrs. Min.	8. Date of Birth	(ear)	9. Birt	hplace (State or Foreign	
218-66-4815	1 ★ □M 2□F	56 Yrs	Months Days Hours	IVIII I.	August 29	, 1954	Mary	yland	
sual Residence of Decedent									
Da. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits	
aryland Baltim	ore	Towson						1 □Yes 2 🛣 No	
De. Street and Number			10f. Zip Code		10	. Citizen of	What Co	untry?	
05 E. Joppa Road	Apt 1106		21286		I	SA			
. Marital Status	12. Was Decedent	Ever in U.S. 1	Was Decedent of Hispanic Original	in? (Spe			ice - Ame	erican Indian,	
Marital Status □ Never Married 2 Marrie	Armed Forces?		If Yes, specify Cuban, Mexican,	Puerto I	Rican, etc.)		ack, White		
3 ☐ Widowed 4 【 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No Specify:			Speci	ite		
15. Decedent		16a De	ecedent's Usual Occupation		10	b. Kind of E	Business/	Industry	
(Specify only highest	grade completed)	(G	ive kind of work done during most (e. DO NOT use retired)	of workii				•	
Elementary/Secondary (0-12)	College (1-4or	5+) Plum	_		Self-Employed				
7. Father's Name (First, Middle, L	1ast)		18 Mother	's Name	(First, Middle, Ma	iden Surna	me)		
					L. Young		,		
9a. Informant's Name/Relationsh		I	ailing Address (Street and Number				n, State, 2	Zip Code)	
John P. Lawrence-Fa	ather		3 Windham Rd., Laur	eı, N					
Da. Method of Disposition		20b. Place of Dis	sposition (Name of crematory or other place)	D	ate 20	c. Location	- City or	Town, State	
1 ☐ Burial 2 【☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp				urel, Maryland					
Signature of Fugeral Service L			22 Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring R	. Inc	C.				
22a Part 1 Enter the	complications that are	the death Dani					20/0/	Approximate	
shock, or heart failure. List of	omplications that cause only one cause on each l	ne.	enter the mode of dying, such as o	aruiac c	л respiratory affes	ıt,		Interval Between Onset and Death	
mmediate Cause (Final lisease or condition	COP	D				20 years			
esulting in death)	Due to (or as	a consequence of):			8				
CONTRACTOR OF THE CONTRACTOR	to b.								
equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury	Due to (or as	a consequence of):							
ause. Enter Underlying ause (Disease or injury									
at initiated events esulting in death) Last	C Due to (or as	a consequence of):							
		·							
	d								
F FEMALE:	000 16	-4							
3b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐ Ectopic pregnancy				ate of de Ionth	•	
1 ☐ Yes 2 ☐ No	4 ☐ Pregnant a		5 Other (specify)			Month Day Year			
9 ☐ Unknown	0.0000000000000000000000000000000000000								
art II. Other significant condition			e underlying cause given in Part I.		23e. Did toba	cco use co	ntribute to	the cause of death?	
Cordibny op a	thy, siec	tion fre	ction 35%		1 ☑ Yes	2 🗌 No	3 □ P	robably 4 🗌 Unknowr	
7	7/-3			_	24a. Was an	2/16	Were	utopsy findings available	
					autopsy		prior to	completion of cause of	
					perform 1 □ Yes 2	No	death?	s 2 ⊘ No	
					1 1 2 100 -				

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trai cate has been signed by the page 2 should be detached certificate this within 24 hours after death. To the Funeral Director: neral Director: , filled in by the f

Physician

/Medical

State

Registrar

DHMH 17 Rev 1/2001

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

-York

Registrar's Signature

28b. Time of Injury

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	L,		1 - State of Marylan Registrar	•	rtificate of Dea		, 0	ene 1. No. 2011	16150		
	Physici	an	1. Decedent's Name (First, Middle, Last)			2	2. Date of Death Month	Day Year	3. Time of Death 1:47 PM		
	/Medic		Harold Paulsgrove Lung				May 5				
	Examin	er	4a. Facility Name (If not institution, give street and number) Village at Robinwood		4b. City, Town, or Local Hagerstown			4c. County of Death Washington County			
***	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	ast birthday)	If Under 1 Year If U		B. Date of Birth		nplace (State or Foreign		
1	Director		216-14-5076 ¹¾M 2□F 90	Yrs.	Months Days Ho	ours Min.	B. Date of Birth (Month, Day, Y Jan. 16,	1921 Mar	yland		
	pug 🛊		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	, Town or Lo	cation				10d. Inside City Limits		
	f short	ō							1 ☐ Yes 2 X No		
	the N	rect	10e. Street and Number VIIIage at Robinwoo	erstow d	10f. Zip Code		100	g. Citizen of What Cou	intry?		
	h with 23a or st the	Funeral Director	19800 Tranquility Circle	-	21742			U.S.A.			
	ems (ner	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of Hispan f Yes, specify Cuban, Me	nic Origin? (Spec	ify Yes or No-	14. Race - Amer Black, White			
36	72 hours after death with the Maryland hatural", or items 23a or 28a-f show doal Evandher I ust be multifud at	by Fu	1 Never Married 2 Married 1 XYes 2 No	- 1	57	ecify:	,,		nite		
21215-0036	hour	ed k	3 Avvidowed 4 Divorced Year or Dates 1945	16a. Deced	lent's Usual Occupation		16	6b. Kind of Business/I			
215	hin 72 e. an "ng	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	kind of work done during OO NOT use retired)	g most of working	'				
2	ad wit	Con	12	Owner				Service St	ation		
Maryland	be filk od oth even	Be	17. Father's Name (<i>First, Middle, Last</i>) Clegget Lung				First, Middle, Ma	· ·			
Σ	hould of Mer marke	2	2	19a. Informant's Name/Relationship (Type. Print)	10h Mailin	g Address (Street and N		ulsgrove		"- C-d-)	
	nd 2 s litth an 27 Is I		Timothy Lung-son	1	Wellspring						
re,	s 1 ar of Hea item		20a. Method of Disposition 20b. P		sition (Name of natory or other place)	Da		c. Location - City or T			
imo	Pages nent of I ant: If ite				Cemetery	5-9-20	0 11 Wa	ynesboro,	PA		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Middel Evanting in ust by realth of a once.		21. Signature of Funeral Service Licensee		. Name and Address of I		glas A.	Fiery Fund	eral Home		
	20 E # 8	12	Kaitin Zaffarone Site		31 Eastern						
		or a	23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause in each line.					3 I	Approximate Interval Between Onset and Death		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	1001	arte	Vasc	word	race	400s		
1	Examiner		Due to (or as a consequ	ience of):		(20)			2		
7	D +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ratice off.							
	ecuted ind transit	Examiner	Cause (Disease or injury that initiated events								
60,	be exection a	Ě	resulting in death) Last Due to (or as a consequ	ience of):							
68760,	tificate be executed g physician and as the burial-transit	edical	d	· · · · · ·	<u>, </u>						
	± 5, α		IF FEMALE: 23c. If yes, outcome of pregnant					23d. Date of deli	verv		
Box	death e atte d for u	icia	in the past 12 months?		Ectopic pregnancy Other (specify)			Month	Day Year		
P.O.	at the by th	Physician/IV	9 Unknown								
Ś	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	2	Part II. Other significant conditions contributing to death but not resu	Iting in the un	derlying cause given in I	Part I.		cco use contribute to			
Orc	w requir	eted	Demarka				1 Ll Yes	No 3 Pro	obably 4 Unknown		
Vital Record	has t	Completed	Hypertension				24a. Was an autopsy performe	prior to c	topsy findings available completion of cause of		
E .			25. Was case referred to medical				1 □Yes 2		2 □No		
	yslcla s cert directo	o Be	examiner? 1 Yes No Hospital: 1 Inpatient 2	EB/Outpatien	0.11	Place of Death		ce 6 ☐ Other (Spec	2(5.1)		
סר	ding Phy h. After thi funeral o	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of Injury	28c. Injury at Work?		d. Describe how		ary)		
Sign	death. ctor: Af the fur	atic	2 Accident investigation	ii ijai y	M 1 □Yes	2 🗆 No					
Division of	Le de la	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e. Place of Injury - At ho building, etc. (Specify	28	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	pital ours a eral D		29a. Certifier LA Certifying Physician: To the best of my know	wiedae death	a occurred at the time, de	ate and place as	and due to the equ	unc(n) and manner as	otated		
	e Hos 24 hc e Fun letely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination	ion and/or inv	estigation, in my opinior	n, death occurred	d at the time, date	e and place, and due	to the cause(s)		
	To the Hospital o within 24 hours aft To the Funeral Di completely filled in	Me	29b. Signature and title of continuous		29c. License num	nber	290	I. Date signed (Month	n, Day, Year)		
	X) ////////// >		1)26	5806	$ \gamma \rangle$	la. 6.	7011		
	-/4	Ì	30. Name and address of person who completed cause of death (Item	23a) (Type, F	Print) / _	1 , -	1.1	17	> >		
	H+1		31. Date filed (Month, Day, Year) 32. Registrar's Signat	Si lu	ia/he/ni	HE [0]	Magen	year, WL	0 61742		
	Stat Registra		MAY 1 0 2011	1. 1	and I		J	-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2:46 Ам Richard M. Long 2011 Mav Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Village at Robinwood Hagerstown Washington County Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Aug. 27, 1922 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Days 220-16-1148 88 Vrs MacryTand Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 Yes 2 No 10e. Street and Number Village at Robinwood 10f. Zip Code 10g. Citizen of What Country? Funeral 19800 Tranquility Circle 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by If Yes, Give Year or Dates 1 Yes 2 No Specify White Specify: 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Owner Office Equipment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Albert M. Long Edith Ernst Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Shepherd-daughter 12912 Woodburn Dr. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Rest Haven Cemetery 5/14/2011 4 Donation 5 Other (Specify) Hagerstown, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home Signature of Funeral Service Licens Kait 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ate has been signed by the atter page 2 should be detached for u in the past 12 months? Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 🗌 Yes Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Ving 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D

completed filled in Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 23815 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Will st. Hagersi 31. Date filed (M State

Registrar

Amended #8, nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04/28/11, per FD, State of Maryland / Department of Health and Mental Hygiene Allegany Co.1 - For State Certificate of Death Reg. Nor 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year James Roy Livingston April 23, 2011 06:07 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 640 East 2nd Street, Apt. 5G Allegany Cumberland 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign 1 M 2 🗆 F Days Months Mir Director Yrs 50 214-84-4227 20 Maryland Usual Residence of Deceden or 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shou 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 640 East 2nd Street Funeral 21502-U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ★ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Disabled Worker McDonalds Fast Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e Ronald J. Livingston, Sr. traumatic Margaret Ann Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Livingston mother 348 Allegany Street Maryland 21532-Frostburg 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Saint Michael's Cemetery April 27, 2011 Frostburg Maryland ture of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic disease or condition 22000 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if ally, leading to immediate cause. Enter Underlying Day to for as a consection of To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? ate has been signed by the atte page 2 should be detached for Month Dav Year Pregnant at time of death Linknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 willetas 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical examiner? Referred by Be 26. Place of Death (Check only one) Other မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral de amino 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury within 24 hours after death.

To the Funeral Director: Af 1 Yes 2 🗀 No filled in by the Investigation
Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 1 | 2 | 2 | 3 | 3 | 3 | roleted Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar esus

Physicia Medic Examir Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and To the funeral director, page 2 should be detached for use as the burial transit Division of Vital Records, P.O. Box 68760

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	State Registrar		Ce	rtificat	te of L	Death		Reg. I	<u> </u>		6	66	
	1. Decedent's Name (First, Middle, Last) Sara Luje	Sara LuJean Loveday						il 2	Day 2011 3. Time of Death 3:00p				
I	4a. Facility Name (if not institution, give street and numb	4b. City		Location of Deat			c. County of De						
ŀ		Brighton Gardens of Tuckerman 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)									omeri		
	416-50-5286 1 ☐ M 2 🗓 F	81		Months	Days	If Under 24 Hrs Hours Min.	8. Date of B (Month, D March	Day Year	1930 Al	9. Birthplace (State or Foreign) Alabama			
Ì	10a. State 10b. County	y, Town or Lo	ocation	Ma	utla Datla	0 t d a			10d.	. Inside C	ity Limits		
	Maryland Montgomery 10e. Street and Number			10f. Zi	p Code	rth Beth	esaa	100.0	Citizen of What	Country'		> 2 (36) N	
	5550 Tuckerman Lane					20852		l log.		1.S.			
	11. Marital Status 12. Was Decec		S. 13.	Was Dece	dent of H	spanic Origin? (S	pecify Yes or No)-	14. Race - Ar	merican	Indian,		
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	Arthur A. Thro	isher					Lena	Mae	Sandliv	l			
	19a. Informant's Name/Relationship (Type, Print)					and Number or Ru							
	Suzanne Rittenhouse - Dai					a Dr., #		rman	itown, N	lary	land	208	
	20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from 9	tate C	Place of Disp cemetery, cre	matory or	other plac		Date		Location - City				
	4 □ Depation 5 □ Other (Specify) Ft. Lincoln Crematory 05/04/2011 Brentwood, Maryland												
	21. Signature of Furreral Service Licensee MOO 709 22. Name and Address of Facility Simple Tribute Funeral Center, 1040 Rockville Pike, Rockvil												
	23a. Part 1. Enter the disease, or complications that ca shock, or hear Hallure. List only one cause on eac	used the deat								Ar	oproximat terval Bet	te	
	Investodiate Course (Cine)	. Pne.u	nonia							nset and I			
	resulting in death) Due to (o	ration ras a consequ	uence of):							1			
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	cause, Enter Underlying	uence of):											
	trial illitiated events	r as a consequ		rotic Heart Disease									
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d. <u>Hypertension</u>													
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown 23c. If yes, outc 1 ☐ Live B 4 ☐ Pregna 9 ☐ Unknown	☐ Ectopic pregnancy ☐ Other (specify) 23d. Date of delive Month					delivery Da	y	Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use									use contribute	to the c	ause of d	eath?	
							1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unkno				Unknow		
						24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No 1 □ Yes 2 □ No							
	25. Was case referred to medical examiner?					ace of Death (Che							
	1 Yes 2 X No Hospital:	patient 2 🗆				4 KJ Nursing F			6 ☐ Other (Sp	ec <i>ify</i>)			
	Tag Hatarai 0 = Folialing	injury Day, Year)	28b. Time o injury	ľ	28c. Injury work	?	28d. Describe	how inju	ary occurred				
		f Injury - At ho , etc. (Specify		M reet, factor		Yes 2 □ No	28f. Location City or To		nd Number or F	Ru <i>ral R</i> oo	ute Numb	oer,	
	29a. Certifier 1 Certifying Physician: To the besic (Check 2 MgCical Examiner: On the basis	of examination	n and/or inves	stigation, in	my opinio	 n, death occurred : 	at the time, date	and place	ce, and due to th	e cause(s) and ma	nner stat	
-	only one) 3 Certifying Nurse Practioner: To 29b. Signature and title of certifier	the best of my	knowledge,	death occu	rred at the	time, date and pla	ace, and due to t	he cause	e(s) and manner	as stated	1.		
	Zeb. Signature and title of centiler			290	c. License			29d. D	ate signed (Mo				
					_	D53691			May 02,	, 20	11		
	 Name and address of person who completed cause Ajay Pulimamidy Reddy, 	,	, , , , ,	,	Oab	s Blud	#110	Rach	villo	MD '	2085	2	
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	31. Date filed (Month, Day, Year) MAY 0 4 2011	istrar's Signat	Agui										

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 04/28/2011 MARY ALMA LOMAX 10:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cherry Lane Nursing Center Laurel Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🗓 F Months Hours 01/16/1916 Yrs Director 95 218-20-1632 Usual Residence of Decedent 28a-f show 10a, State 10h County death with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No MD Howard Laurel 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 9571 Cissell Avenue 20732 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 0 ģ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black "natural" 3 X Widowed 4 ☐ Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 In and Mental Hygiene. T is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) the 12th Supervisor Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arthur Jones Blanche Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a ant: If item 27 is 9566 Cissell Avenue, Laurel, Phillip F. Lomax, Jr./son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/04/11 Meadowridge Mem Pk Elkridge, MD 21 Signature of Funeral Service Liber 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) Dementia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-track that initiated events resulting in death) Last and ш Due to (or as a consequence of): attending physician I for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Acute renal failure Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Yes 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral director. မ 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D45217 04/29/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Ade Ajayi, MD

31. Date filed (Month, Day, Year)

MAY 0 4 2011

6201 Greenbelt Road, Sute M18, College Park, MD 20740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) 2011 **Physician** 29, April 2240 Eunice Louise Nickens LeCesne /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Montgomery Silver Spring Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1 M 2 DX 95 323-40-5979 Director June 8. 1915 Gainesville, VA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 'natural", or items 23a or 28a-f show dical Examiner must be notified at 1 √Yes 2 No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 3128 Gracefield Rd. United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours afterment of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or ite ury or other traumatic event, the Modical Examination. 1 □ Yes 2 **X**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2 🕱 No Specify: Specify: Colored 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chicago Public Schools Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ James Maxville Nickens Susie Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 any injury or other troone. Enid Brown Marshall/niece 1205 Firth of Lorne Circle Ft. Washington, Md 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Hillside, Il Dueen of Heaven Cemetery 5/9/11 7400 Georgia Ave. N 22. Name and Address of Facility 21. Signature of Funeral Service License Washington, DC 20012 McGuire Funeral Service Inc. 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Dementia /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury Due to (or as a consequence of): law requires that the death certificate be executed Hypertension that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) signed by the a Yes 2 No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Chronic kidney disease 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an Anemia, Osteoarthritis 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 al or Attending F after death. I Director: After d in by the funera 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled in Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

DHMH 17 Rev 1/2001

2

31. Date filed (Month, Day, Year) 0 4 2011

29b. Signature and title of certifier

32 Registrar's Signature

ALEXION

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month. Day. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ^{Day} 2011 7:05A M Carrie Virginia Long May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital 01ney Montgomery Social Security Number If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Country) Virginia 7. Age (In yrs. last birthday If Under 24 Hrs. 6. Sex **Funeral** 1 🗆 M 2 🗓 F (Month, Day, Year) 26. 1952 Months Days Min 58 **Director** Oct. <u>216-64-5812</u> Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State items 23a or 28a-f sho ner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Frederick Ijamsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2735 Loch Haven Drive 21754 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U.S. Postal Elementary/Seconday (0-12) College (1-4 or 5+) 12th Clerk Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frederick Brittain Dorothy Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert D. Long - Husband 2735 Loch Haven Drive, Ijamsville, Maryland 21754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Kcremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematorium 5/07/11 Alexandria, Virginia 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home Signature of Fu neral Service License 26401 Ridge Road. Damascus, Maryland 23a. lmm Physician/ disea Medical Examiner Sequif any cause Cause Examiner attending physician and I for use as the burial-transit that Be Completed by Physician/Medical death certificate be IF FE 23b. V signed by the at Id be detached fo Part I funeral director, page 2 25. W ex 1 10 27. M Medical Certificate: 4

P.O. Box 68760 Division of Vital Records, To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has k

23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	plications that caused the death. Do not enter the ne cause on each line.	mode of dying, such as cardia	or respiratory arrest,	Approximate Interval Between						
Immediate Cause (Final disease or condition	Sepsis			Onset and Death						
resulting in death)	Due to (or as a consequence of):									
Sequentially list conditions,	Phenmenin									
if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):									
Cause (Disease or linjury that initiated events	· Vulvar Cancer									
resulting in death) Last										
	d.									
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delivery						
in the past 12 months? 1 Yes 2 No		opic pregnancy er (specify)		Month Day Year						
9 Unknown	9 Unknown									
Part II. Other significant conditions co	ontributing to death but not resulting in the under	ying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?						
			1 🗆 Yes	2 No 3 Probably Unknown						
			24a. Was an	24b. Were autopsy findings available						
			autopsy performed?							
25. Was case referred to medical		26. Place of Death (Che	1 Yes 2	No 1 ☐ Yes 2 🗷 No						
examiner?										
27. Manner of Death	1 Ampatient 2 ER/Outpatient 3 28a. Date of Injury 28b. Time of	DOA Other: 4 Nursing I	Home 5 Residence							
1 Natural 5 Pending	(Month, Day, Year) injury	work?	28d. Describe how inju	ary occurred						
2 Accident Investigation 3 Suicide 6 Could not be										
4 Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street a City or Town, Star	and Number or Rural Route Number, te)						
5/	10									
(Check 2 L Medical Examin	ician: To the best of my knowledge, death occur ner: On the basis of examination and/or investigation e Practioner: To the best of my knowledge, death	n, in my opinion, death occurred	at the time, date and place	ce, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier	. `	29c. License number		Date signed (Month, Day, Year)						
	77	D68658	5	/2/11						
30. Name and address of person who c	ompleted cause of death (Item 23a) (Type, Print)		l .							
Alex Kinnain	M.D. 18101 Prince F	hilip Drive,	Olney, Md.	20814						
31. Date filed (Month, Day, Year) NAY 0 4 2	32 Revietrar's Signature	Nest.								
	ORIGINAL									
	0.000									

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death April 29, Day 011 Year Physician/ Lewis-Wormley Laverne Α. 1916 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince George's Cheverly Prince George's Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number **Funeral** 579-46**-**6605 1 □ M 2 🛣 F Months Hours 10/06/1935 DC Director Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s er must be notified 1 X Yes 2 No DC N/A Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 401 Chaplin Street Southeast 20019 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ö 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Black Specify "natural", 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private <u>Telephone Operator</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental I Department of Health and Menta Important: If item 27 is marked: any injury or other traumatic and once. ည Virginia M. Keith Gordan S. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Wormley/ Husband 401 Chaplin St., SE, Washington, DC 20019 altimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - Cíty or Town, State Date cemetery, crematory or other place)
Heritage Cemetery May 7, 2011 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Pope Funeral Homes, P.A. ure of Funeral Service Licer 21. Sign 5538 Marlboro Pike, Forestville, Maryland 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Asystole <u>30 min</u> / Medical resulting in death) Due to (or as a consequence of): **Examiner** 45 min. Hypoxia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami burial-transit Cause (Disease or imjury that initiated events Seizures hour and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Cerebral Vascular Accident yrs P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No Year Month Day the i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Asthma, Chronic Obstructive Pulmonary Disease Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Pulmonary Fibrosis 24a. Was an page 2 s has performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 24 hours after death. Funeral Director, After this certific leted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 X ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) umarsha 15-02-2011 MD 25618 MMS

DHMH 17 Rev 7/2009

State Registrar Suite#130, Hyattsville, Maryland 20782

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6525 Belcrest Road

Date filed (Month, Day, Yes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 25,27,28a-f per me, g916,06/3/2011dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 3:50 Medical Elsie May Moser 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington County Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)

Maryland **Funeral** Age (In vrs. last birthday) 8 Date of Birth 1 - M 2 X F Days Hours (Month, Day, Ye Director 215-42-3773 94 Sept 1916 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at within 72 hours after death with the Maryland 10b. County Director 10c. City, Town or Location 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11618 Pheasant Trail 21742 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 XNo 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: 3 ★ Widowed 4 □ Divorced Completed Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmain. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kirby Smith Conner Mary Lee Spitler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Kline, son Main Street, PO Box 163, Keedysville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rose Hill Cemeterv 5/13/2011 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility A.K. Coffman Funeral Home, Inc. R. hoel 21740 40 East Antietam Street. Hagerstown, 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) UADURAL HEMATOMA 4-36 400 Medical Due to (or as a consequence of) Examiner DEPTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the bunial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 moons
1 Yes 2, No Dav Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à FIRELLATION, CEREBROVASCULAR 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed DEBILITATED STATE, MALNUTRITION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific Division of Vital To Be 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner? Other: Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniurv 5 Pending 2 X Accident work? 1 ☐ Yes 2 🕱 No 05/06/2011 **Unknown** M Investigation Subject fell 6 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, City or Town, State) 11618 Pheasant Trail, Hagerstown, MD 4 Homicide determined Home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and title of certifier 29c. License number 138892 Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 130 HAGGRITOWN, FOX MB PORI 11110 MEDICAL

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 4, Terrence Wayne MARTIN Sr. 2011 9:40 a. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 8. Date of Birth (Month, Day, Year) Sept. 21,1945 If Under 1 Year If Under 24 Hrs. Funeral . Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 | F Days Hours Mary Land 214-46-5179 Director 65 Usual Residence of Decedent 28a-f show 10a. State 10h County with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 X No WV Berkelev Falling Waters 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 125 Crawford Quarry Road 25419 USA items death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ö δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 X No Specify "natural", Specify white Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) ceramic tile installer tile company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Victor Martin Sr. Phyllis Virginia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health : Kimberly Martin - daughter 485 Dinali Dr., Martinsburg, WV 25403 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Department Important: If any injury or once. Rose Hill Cemetery 5/9/11 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) MINNICH FUNERAL HOME 22. Name and Address of Facility 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. val Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner burial-transit and Due to (or as a consequence of): inding physician use as the burial Physician/Medical death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Day Pregnant at time of death Month Year signed by the a d be detached fi the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 res 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 After this certificate has autopsy performed 1 Yes 2 🗌 No • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific Division of Vital 25. Was case referred to man funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ဂ 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifie 29c. License number 2 29d. Date signed (Month, Day, Year, ted cause of death (Item 23a) (Type, Print

State Registrar

WH-3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 9 per FH G915 5/20/11 dk State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day McKinser eorgetta IRENE 2:25PM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Julia Moror Health Care Washington Haberstown If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. Sept. 23, 1927 Mary Tand Director 83 218-38-1379 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Maryland Washington Hagerstown Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21740 121 East Antietam Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 white If Yes, Give Year or Dates 1 Tes 2 X No Specify: 3 Wildowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) her own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 (unknown) Susan Mark Garnard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 813 Virginia Avenue, Hagerstown, Maryland 21740 Linda Fultz - daugher-in-law Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State Hagerstown, Maryland Hagerstown Crematory May 7,2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Kol & East Wilson Blvd., Hagerstown, Maryland 21740 Kon 415 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Day Month Year Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Schizophrenia, Major Depression, Ostcoarthatis Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Reigheral Vascular Disease 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has this certificate Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 🗌 Yes 2 🗓 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After iniury 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: Af 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 U Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 6/11 R125360 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Blucher -333 Mill Street, Hoberstown, MD 21740 N3H-0 Barbara egistrar's Signature 31. Date filed (Mor State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 25 per me /8915 5-20-11 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ McDermott Bridget Ann Year ۱۱ ن Medical 4c. County of Death Allegany 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Western MD Regional Medical Center Cumberland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Pennsylvania Months Hours Min 172-18-9541 90 **Director** 10/08/1920 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 72 hours after death with the Maryland 10c. City. Town or Location Director MD LaVale Allegany 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 10600 Cash Valley Road, NW Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Vasilko Elizabeth John Krempasky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10600 Cash Valley Road, NW, LaVale, MD 21502 Francis H. McDermott / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Vet Cem @ Rocky Gap 05/09/2011 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State MD Vet Flintstone, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, F.A. of Funeral Serlvic 404 Decatur Street, Cumberland, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ntracerdora disease or condition resulting in death) Medical CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Examiner Sequentially list conditions, Examine If any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Physician: The law requires that the death certificate be executed and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical of Vital Records, P.O. Box 68760 IF FFMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) the g 🗌 Unknown þ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certified completed filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Division Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Destriction of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11 DOG 39811 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jerry Adams, M.D., 12500 Willowbrook Road, Cumberland, MD 21502

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MAY 0 6 2011

anka.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) $\overset{\text{Day}}{2}\underline{011}$ April McLachlen Year Esther Physician/ 9:15 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Maplewood Park Place Bethesda 9. Birthplace (State or Foreign Social Security Numb Age (In yrs. last birthday)
91 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours 1 □ M 2 🗶 F 043-16-6644 Bridgeport, Nov CTDirector Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2 No Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20814 United States Funeral 9707 Old Georgetown Rd #2205 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2X☐ No Black, White, etc. 1 Never Married 2 Married ş Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give 3 Widowed 4 □ Divorced "natural", Completed Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 i.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Private</u> <u>Secretary</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Jennie Westman Antonio DeLeon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7509 Nutwood Ct, Derwood, MD 20855 William McLachlen/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State May 2,2011 Falls Church, VA 4 Donation 5 Other (Specify) National Crematory 22. Name and Address of Facility Joseph Gawler's Sons Inc. Signature of Funeral Service Licenser 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Cerebral Vascular Disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and and resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 9 Unknown be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Interstitial Lung Disease Completed page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? Severe Kyphosis within 24 hours after death.

To the Funeral Director; After this certificate has completed filled in by the funeral director, page 2 s autopsy performed? 1 🗌 Yes 2 🗌 No Yes 2 XNo Pulmonary Hypertension 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🛣 No Certificate: To 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred injury 1X Natural 5 Pending Investigation Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number April 29, 2011 D55258 well ځ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary B. Wilks MD 7758 Wisconsin Avenue #211 Bethesda, MD 20814 31. Date filed (Month, Day, Year) State MAY 0 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month George Marcou April 28. 11:40 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9707 Old Georgetown Rd #2409 Montgomery Bethesda Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
12-4-1928 Birthplace (State or Foreign Country) **Funeral** 1 🗆 🕅 2 🗆 F Months Days Hours Min. Director Egypt 004-34-7714 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Ħ 10c. City, Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified Yes 2 No Montgomery Bethesda 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 20814 United States 9707 Old Georgetown Rd #2409 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married Black, White, etc. ò δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White "natural" 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene, ant: If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) City Planner Private Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Sumame) မ Themistoclis Marcou Maria Kouanis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9707 Old Georgetown RD, Bethesda, MD 20814 Margaret Marcou/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cem 5-3-2011 Washington DC 21. Signature of Funeral Service Licen 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 g Unknown 9 Unknown detached • Hospital or Attending Physician: The law requires that the 24 hours after death.
• Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe Type II Diabetes 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Atrial Fibrillation 24a Was an cate has , page 2 s autopsy performed? Yes 2 1 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 KNo Hospital: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at wo**r**k? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 29, 2011 D55258

Registrar DHMH 17 Rev 7/2009

15

State

Box 68760

P.O.

Records,

of Vital

Division

Gary B. Wylks MD 7758 WIsconsin Avenue #211 Bethesda, MD 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAY 04 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY Physician/ 2011 MAURICE EDWARD MILLER 12:00 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 6. Sex 1 K M 2 D F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 0671771937 Director 217-34-1778 MD Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🏝 No Frederick MD Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21703 5791 Box Elder Court USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? 1 → Yes 2 □ No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify: If Yes, Give and Mental Hygiene.

is marked other than "natural", 3 Divorced Specify: Year or Dates 1955-58 White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 sheet metal mechanic metal fabricator of Health and Mental Hygi of Health and Mental Hygi fitem 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rogers F. Miller Margaret Jacobs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Sharon Miller/wife 5791 Box Elder Court, Frederick, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Resthaven Mem. Gar. 5/7/2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, 6 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, shock, or heart failure Lis or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest t only one cause on each line. Interval Between Onset and Death esophagael CANCER Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) rsician and burial-transit Exami requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Physician: The law autopsy
performed?
Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 21 No Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier MDH64135 5/3/// 400 W 7th St 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MASAN Trederick Memorial 5 + IVA State Registrar

Box 68760

Records, P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ 01 04:33 A. Leaver F. Murray May Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Center Cheverly Prince George's Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 11/17/1926 1 □ M 2**X** F **Director** 577-36-2093 Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director 1 ¥ Yes 2 □ No D.C. Washington 10g. Citizen of What Country? ō 10e. Street and Number 10f. Zip Code ian "natural", or items 23a or Medical Examiner must be Funeral 703 56th Pl., N.E. 20019 U.S.A. death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 within 72 hours after Black If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Completed 3X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11th Foster Parent Human Services Be permit. Page 1 and 2 should be filed. Department of Health and Mental Himportant; If item 27 is many injury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Warren Briscoe Elizabeth Fowler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kyra C. Murray/Daughter 703 56th Pl., N.E., Washington, D.C. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Harmony Mem. Park 05/09/11 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Henry S. Washington & Sons Co., Inc. Signature of Funeral Service Licenses ancu 4925 Burroughs Ave., N.E., Washington, D.C 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequente of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events -transit The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician a sthe burial-l Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Live 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy pertormed? Yes 2 No has after death.

Director: After this certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medica filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 은 1 Yes Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending ☐ Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: On the basis of examination and/or investigation, in my optition, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) D7109

State Registrar

8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month 05 Physician/ 7.35 PM rie 201 Medical 4a. Facility Name (if not institution, give **Examiner** 4b. City, Town, or Location of Death 4c. County of Death a 6. Sex If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday 9. Birthplace (State on Foreign Security Number **Funeral** Months Hours Min Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location aţ 10a. State 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified 1X Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes No Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify "natural", 3 Widowed 4 ☐ Divorced Completed ni event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY U.S.GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev THOMAS BUCK HIGDON BESSIE SIMMONS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 BLAND DR., WAYNE T. HIGDON/NEPHEW INDIAN HEAD, MD 20640 20a. Method of Disposition 20b. Place of Disposition (Name of MAY Date 20c. Location - City or Town, State 1 Burial 2Cremation 3 Removal from State METRO, CREMATORY 14,2011 ALEXANDRIA, VA 4 Donation 5 Other (Specify) 22. Name and Address of FacilityRAYMOND FUNL. SERVICE, P.A. M00641 5635 WASHINGTON AVE. , LA PLATA, MD 20646 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each live. Onset and Death Immediate Cause (Final Ph. sician disease or condition resulting in death) Medical **Examiner** Sequentiary flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami tran and Due to (or as a consequence of): g physician ar as the burial-t Physician/Medical The law requires that the death certificate be P.O. Box 68760 attending pt d for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknow signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🜠 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director. After this certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 **X**No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident 1 Yes 2 No Investigation 6
Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe 10270 Old Line Center Kaufman Waldorf MD 31. Date filed (Month, Day State 1 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Fravon Dashon N		1- For State	tate of Maryla		artment of rtificate of		id Mental I		Reg. No. 201	1 16176	
Physicia	n/	Registrar 1. Decedent's Name (First, Mide						2. Date of Dea	ath Day Year	3. Time of Death	
Medical Examin	ıer	Tra Von 4a. Facility Name (if not instituti	D. Nicho	April 29, 2	2011 4c, County of	2303 nrs					
		4539 Houseton Brane				City, Town, or Location of Death Federalsburg 4c. County of Death Caroline					
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs.				last birthday)	If Under 1 Yea			Birth(MM/DD/YYYY) 9. Birthplace (State or		
Director		219-33-6639	1 X M 2 F	19	Yrs	Months Day	s Hours M	in. 11-0	8-1991	Foreign Country) Md.	
	ļ	Usual Residence of Decedent 10a. State 10b. County		140° Cit.	. Town or Locat					10d. Inside City Limits	
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ryland	흸	De. Sus	ssex	Sea	aford	10f. Zip Code		1	10g. Citizen of Wha		
he Ma 1 or 28	Director	1901 N. Oal	Grove R	nad.		19973	,	1	USA		
with 1	區	11. Marital Status	12. Was Dece	edent Ever in U		s Decedent of Hi	spanic Origin? (American Indian, Black,	
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	1 Never Married 2	2 X No			n, Mexican, Puer	to Ricari, etc.)				
rs afte ural",	à	3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 No specify: Specify: B 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business							Black iness/industry		
72 hou	Completed	Elementary/Secondary (0-12)					DO NOT use re			•	
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filed v Hygivan the filed v		17. Father's Name (First, Middle	e, Last)						Maiden Surname)		
212 ald be Menta marke	To Be	Darrell 19a. Informant's Name/Relation	ship (Type, Print)	Ni	chols 19b. Mailing	Sr. Address (Stree	Yola: et and Number or		Macer mber, City or Town	, State, Zip Code)	
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 27 is marked other than umatic event, the Medical	7	Yolanda Ma	cer/Moth	er	617	Jacks	Lane, F	ederals	sburg Mc	3. 21632	
re, l s 1 and f Heal f item		20a. Method of Disposition 1	_	20b.	Place of Dispos crematory or oth	ition (Name of ce ner place)					
Pager Par Pager Pager Par Par Par Pager Par Par Par Par Par Par Par Par Par Pa		4 Donation 5 Other S	Specify:		Reids (rove C				sdale,Md.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	M	21. Signature of Funeral Service	1	6		ame and Addres	Δ,	ennie S	Smith Fu	neral Home 21643	
Physician		23a. Part I. Enter the disease, o	r complications that ca	used the death	n. Do not enter th	o 16 Mai ne mode of dying	n Stree , such as cardiac	or respiratory an	rest, shock, or hear	Approximate Interval	
Medical,	1	failure. List only one cause Immediate Cause (Final disease	e on each line.							Between Onset and Death	
Examiner	-	or condition resulting in death)	Due to (or as a		of):						
	۱	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence o	of):						
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		IF FEMALE: 23b. Was decedent pregnant in t	ho —	utcome of preg	nancy				23d. Date of d		
ox 687 eath certifu	San	past 12 months?		rth int at time of de		tal death 3 ner (Specify)	Ectopic pregr	nancy	Month	Day Year	
Box 6876C e death certificate the attending physed for use as the br	Physician/Me	1 Yes 2 No 9 Ur	nknown g Unknow	w n	• 0	lei (Speedy)					
that the	by P	Part II. Other significant condi	tions contributing to	death but not r	esulting in the u	nderlying cause	given in Part I.			ute to the cause of death? Probably 4 Unknown	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted in the funeral director.	ᅙ							24a. Was		ere autopsy findings available	
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Vital Rec ysician: The l his certificate l director, page		25. Was case referred to medical	al			26 Place	e of Death (Chec	1 Yes	2 No 1	Yes 2 No	
Vital ysiciar his cer directo	mĭ	examiner? 1 ✓ Yes 2 No	Mosnital:	patient 2	ER/Outpatient		0.11		Residence 6	Other: Scene	
ing Ph	일	27. Manner of Death	28a. Date of (Month) Apr 29, 2	of Injury Qay,Year)	28b. Time of le		ury at Work?		how injury occurred		
Sion Attendi death. ector:	읋		estigation		2240 hrs		Yes 2 ✔ No				
Divisal or At a safter d	Certification:	dete	ild not be	of Injury - At h		et, factory, office i	building, etc.	or Town.	State)	r or Rural Route Number, City , Federalsburg, MD	
Division Hospital or Attent 24 hours after death Funeral Director: stely filled in by the	ဒ္ဓို	4 Homicide	Physician: To the best			red at the time. d	ate and place, ar	1			
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	edical	one) 2 Medical Ex	aminer: On the basis of and manner sta	f examination a	and/or investigat	ion, in my opinion	n, death occurred	at the time, date	and place, and du	e to the cause(s)	
H 3 H 8	\$	29b. Signature and title of certifi		12		29c. Licens				(Month, Day, Year)	
		Aller	grasse 4	MX		O.C.	M.E.		April 30, 20	11	
3		 Name and address of person Melissa Brassell, MD 	· ·		nor 000 M	. Baltimore S	Street, Baltim	ore, MD 212	23		
Sta	ite			gistrar's Signati	ure	Baltimore					
Registr	ar	MATU	* ZUII /	new	1. U.						

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 23a per med cert G916 6/20/11 dk
State of Maryland 7 Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 221 Month Year Phyllis Catherine NEEDY P M yn Ay 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min May 28, 1934 217-74-3324 76 **Director** Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9409 Garis Shop Road 21740 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc þ 1 X Never Married 2 Married 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea College (1-4 or 5+) Elementary/Seconday (0-12) none profit packaging Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry D. Needy Helen Jane Itneyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iris C. Stickell - sister 136 Buttercup Drive, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 K Burial 2 Cremation 3 Removal from State May 10,2011 Hagerstown, Maryland 4 Donation 5 Other (Specify) Rose Hill Cemetery Signature Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 4 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death AMOYLC Ph_sician/ Bruin disease or condition resulting in death) MIMU Medical Due to (or as a consequence of) Examine 2 cue Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit cerebrovascular accident and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months 4 ☐ Pregnant 9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has I autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital: 2 - No 1 Impatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 Queallo 1100611 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JW-3 nen asco and el) 31. Date filed (Month, Day, Year) State MAY 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 9916 6-6-11 yt. State of Maryland/Department of Health and Mental Hygiene 2 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Maria Eugenia Orellana 2<u>011</u> Month Physician/ E May 8:00A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1836 Metzerott Road #1219 Prince Georges Hyattsville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) F. L. Salvador **Funeral** Months Hours (Month, Day, Year) Feb. 10, 1980 31 Yrs. Director 217-65-0270 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 X Yes 2 No Hyattsville MD PG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P er than "natural", or items 23a on the Medical Examiner must be Funeral 1836 Metzerott Road #1219 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? þ 1 Never Married 2 X Married 1 ▼ Yes 2 No Specify: Salvadorian Maryland 21215-0036 If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Hispanic 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Wine Packer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Inportant: If item 27 is marked any injury or other traumatic ev ones. 2 Facundo Gutierrez Reina del Carmen Chicas Goches 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1836 Metzerott Road #1219
Hyattsville, MD 20783 Isaias Orellana/husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 4/9/11 cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) of Heaven Cemetery Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the 38 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Year Pregnant at time of death signed by the at the detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Tyes plnous Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 2 No certificate 1 Yes : After this certifical funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No 24 hours after death. e Funeral Director: A pleted filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 29b. Signature and title of certifier 29c. License number Assistant 0058065 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 50 th 110

Registrar
DHMH 17 Rev 7/2009

State

32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Charles William Porter 41 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Western MD Regional Medical Center Allegany Cumberland 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 6. Sex **Funeral** Age (In yrs. last birthday) Days Min 1 1/19 7 192 Mary Land 1 💢 M 2 🗆 F 89 212-18-1818 Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director MD Allegany Cumberland 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 716 Shawnee Avenue 21502 USA Funeral items 23a 12. Was Decedent Ever in U.S.
Armed Forces?

1

↑ Yes 2 □ No 1942—
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. . or þ 1 Never Married 2 X Married uld be filed wum.
Id Mental Hygiene.
The matural", o 1 ☐ Yes 2 X No Specify. White Specify. 3 Divorced Completed 1945 Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Utilities Serviceman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Porter Pearl Andrew Emma should be and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Maijing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 716 Shawnee Avenue, Cumberland, MD 21502 Lena Mae Porter / Wife 1 and 2 s of Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State MD Vet Cem @ Rocky Gap 05/09/2011 Flintstone, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ARDIAC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last idiler Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month 5 Other (specify) Pregnant at time of death ed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð - Uncontrolle 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? - Stage IV 24a Was an performed 2 W No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the roop within 24 hours after construction and the Funeral Director. After time completed filled in by the funeral director. မ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tyes 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Division of Vital

Medical

29a. Certifier (Check

29b. Signature and title of certific

George

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pelligrino,

M.D.,

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Registrar

29d. Date signed (Month, Day, Year)

21502

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

200 Glenn Street, Cumberland, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State RegistrarAMEND#23eperMD, 5/9/11; RMW, Mo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MAY 20 jea RICHARD COLLINS PINKHAM 4:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □XM 2 □ F Months Days Hours Min. (Month, Day, Ye JULY 14 Year! Director 011-20-2353 86 1924 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD. PRINCE GEORGES HYATTSVILLE 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 5606 37th AVE. 20782 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examination of the programment of of th Completed by 1X Yes 2 □ No If Yes, Give WWII 1 Yes 2 No Specify: 3 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PATENT EXAMINER FED. GOV'T. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ CHARLES PINKHAM JOSEPH SARAH COLLINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5606 JOAN F. PINKHAM/WIFE HYATTSVILLE, 37th AVE., MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) CHAMBERS CREMATORY 5-4-2011 RIVERDALE, MD. 21. Signature of Funeral Service Denses CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final HOKING ON PIECE Obset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) W that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death Year 2 🗌 No g 🗌 Unknown g Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ě To the Hospital or Attending Physician: The law requires it within 24 hours after death.

To the Funeral Director: After this certificate has been sign and propered filed in by the funeral director, page 2 should be pompleted filed in by the funeral director, page 2 should be Division of Vital Records, Completed 1 Yes 2 No 3 Trobably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗀 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 4 23 2011 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending While 21:00 PM 1 Yes 2 🗹 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. lace Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) HOME Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D 0064024 29d. Date signed (Month, Day, Year) 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

TANNA LACHTCHININA, M. D 7600 CARROLL AVE 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

0 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 20^{Year}1 7:54A M Medical Yvonne M. Prvor 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death E1kton Ceci1 Union Hospital **Funeral** Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🂢 F 04-14-1944 Director North Carolina 222-26-9500 Usual Residence of Decedent or 28a-f show 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 💢 No Ceci1 Maryland E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 108 Liberty Lane 21921 United States should be filed within 72 hours after death v and Mental Hygiene. is marked other than "natural", or items 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2 **X** No f Yes, Give 1 Yes 2 X No White Specify Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) <u>Bookkeeper</u> Bookkeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mont Important: If item 27 is marked any injury or cat. Eva M. Marshall Elmer A. DeMuth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Tims Lane, Hockessin, Delaware 19707 John W. Pryor/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State 05-05-2011 me. P.A. 4 ☐ Donation 5 ☐ Other (Specify) Rising Sun, Maryland Foard Funeral 21. Signature of Juneral Service License 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. East Main Street, Elkton, Maryland 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or 😘 a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a conse uence of): burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use yes, outcome of pregnancy

Live Birth 2
Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy detached for in the past 12 months? Pregnant at time of death Other (specify) Month Day Year 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury work? Accident Investigation 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D005950

State Registrar 30. Name and address of person who comp

31. Date filed (Month, Day, Year) NAY 0 6 201

N. Bridge Street, Elkton

eted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2020 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisbury 3158 Md. Wicomice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 i Hours Director Pennsylvania Usual Residence of Decedent 28a-f show 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 105 Times Square 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. \$ 1 Never Married 2 Married Yes 2 K No Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Home Elementary/Seconday (0-12) College (1-4 or 5+) Owner/operator Child Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Linford Eugene Ramsey Florence Kelly 19a. Informant's Name/Relationship (Type, Print)
Vernon L. Payne Jr/son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
113 Tall Timber Lane, Fruitland, MD 21826 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Beth Eden Tilghman Hill Cemetery 4 Donation 5 Other (Specify) 5/6/2011 Pocomoke City, MD Service Licensee Home Professional Association CFSP 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death ¬hysician/ 5 years disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed has been signed by the attending physician and ge 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of the funeral director, page 2 autopsy within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Yes 25. Was case referred to medical Be B 26. Place of Death (Check only one) examiner? 1 Tes ျှ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 300 D051359 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TO USHA NATESAN 415 S. DIVISION ST 21804 SALISBURY,

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Physician/ 20 T .Рм 1416 Gary Lewis Peterson, Sr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil 2528 Appleton Road E1kton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 28, 1948 1 🕅 M 2 □ F Days Hours Min. Maryland 62 Yrs. Director 216-52-6120 Usual Residence of Decedent 28a-f shov 10d, Inside City Limits 10a, State 10b. County 10c. City, Town or Location must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Ceci1 E1kton Maryland 10e, Street and Number 10f, Zip Code ь 10g. Citizen of What Country? Funeral or items 23a United States 21921 2528 Appleton Road 12. Was Decedent Ever in U.S. Armed Forces? 1968-1 Yes $2 \square$ No 1972 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1972 1 ☐ Yes 2 🔀 No Specify. Specify: "natural", 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F ည Lewis Arthur Peterson Sarah Louise Hook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health Jane E. Peterson/Wife 2528 Appleton Road, Elkton, MD or other 20b. Place of Disposition (Name of Cherry Hill Methodist Cemetery 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important; If it any injury or o May 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cherry Hill, MD 2011 Hicks Home for Funerals, P.A. of Funeral Service Licensee 22. Name and Address of Facility 103 W. Stockton Street, Elkton, MD 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? the Funeral Director: After this certificate has been signed npleted filled in by the funeral director, page 2 should be de Ś 1 Yes 2 No 3 Probably Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director: After Natural 5 Pending 2 🗌 No 1 🗌 Yes Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier -Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check ithin 2 the F

State Registrar

29b. Signature and title

Date filed (Mont

23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ FUI	partment of Health and Mental Hygier	2011 16101
			Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death Reg. 2. Date of Death	No CU 5 G 4
	Physici	an		Month May	Day 20 1 11 33AM
i .	/Medic		4a. Facility Name (If not institution, give street and number)		4c. County of Death
1	Examir	er	The Johns Hopkins Hospital	Baltimore City	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min. (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		221-18-3269 The state of Decedent Page 1 and 2 AF 1 and	JUN 07,19	MILFORD, DE
	yland Jow		10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	death with the Maryland	ctor	DELAWARE SUSSEX COUNTY MILLSBORG		1 X Yes 2 □ No
	or 28	Funeral Director	10e. Street and Number	10f. Zip-Code 10g.	Citizen of What Country?
	ath w	ra	200 MILL CHASE, APT. 47		JNITED STATES
	item:	Į.	11. Marital Status 1 □ Never Married 2 ▼ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Ves 2 ▼ No	. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-0036	De filed within 72 hours after death with the Marylan rial Hygiene. ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ▼ No Specify:	Specify: WHITE
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2121	thin 7	nple	Elementary/Secondary (0-12) College (1-4 or 5+)	DO NOT use retired)	DE OF A VIDANT
21	ygien ygien ner th		11 17. Father's Name (First, Middle, Last)	WAITRESS 18. Mother's Name (First, Middle, Main	RESTAURANT
Maryland	should be filed within 72 hours after of Mendle Hygiene. and Mendle Hygiene. marked other tipan "natural", or Ite matic event, the Medical Examiner	Be	HARRY J. DAVIS		
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ē,	permit. Pages 1 and 2.8 Department of Health ar Important: If item 27 Is any injury or other trau		20a. Method of Disposition 20b. Place of Disposition	position (Name of Date 20c	: Location - City or Town, State
Baltimore,	permit. Pages 1 Department of I Important: If ite any injury or ot once.		Table 2 Gronnation of the most of the state	omatory or other place) ORO CEMETERY MAY 12,2011	ITLISBORO, DELAWARE
alti	permit. Departm Importal any inju	Ì		22. Name and Address of Facility	19966
8	8 8 E 6 8			WATSON FUNERAL HOME PO BOX	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respiratory arrest,	Approximate Interval Between Onset and Death
Æ	Physician		Immediate Cause (Final disease or condition a. Respiratory For resulting in chordion	ulure	Onset and Death
뎋	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Respectively. For the Form For the Form Form Form Form Form Form Form Form	6 0	
		-	Sequentially list conditions, bb.	Syndroma	
	rted insit	Examiner	Sequentially list conditions, if any leading to firm rediate cause. Enter Underlying Cause (Disease or injury		
	execu n and rial-tra		that initiated events ' c. resulting in death) Last		
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d		
.89	rtifica ng ph e as tl	- O	IF FEMALE:		
Вох	ath ce tendir or use	ian	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 \subseteq Live birth 2 \subseteq Fetal death 3	☐ Ectopic pregnancy	23d. Date of delivery Month Day Year
). E	es that the death certific gned by the attending p I be detached for use as	Physician/M	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)	
P.O.	that the detack		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobac	co use contribute to the cause of death?
Records,	signe ld be	d by		1 ☐ Yes	2 No 3 ☐ Probably 4 ☐ Unknown
00	law require as been sig 2 should l	lete		24a. Was an	24b. Were autopsy findings available
Re	he lar e has age 2	Completed		autopsy performed 1	prior to completion of cause of death? 1
	siclan; The certificate irector, pa	BeC	25. Was case referred to medical	26. Place of Death (Check only one)	
of V	Physiclan: this certifica eral director,	10 E	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Other: 4 Nursing Home 5 Residence	e 6 🗆 Other (Specify)
Ē	ng Pl	ü	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 1njury	Work?	injury occurred
Division	tendi death. tor: A the f	cati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, si	M 1 Yes 2 No	at and Number or Rural Route Number,
Ď	or At after of Direct in by	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, St	
_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	a C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, and due to the caus	se(s) and manner as stated.
	n 24 h	edical	(check only one) 2 Medical Examiner: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occurred at the time, date	and place, and due to the cause(s)
	vithii To th	Me	29b. Signature and title of certifier	29c. License number 29d.	Date signed (Month, Day, Year)
			Bennett all, MD	2ES-000 Y	May 6, 2011
			30. Name and address of person who completed cause of death (Item 23a) (Type		Ct Deltimore MD 04007
			Bennett Clarlz 31. Date filed (Month, Day, Year) 32. Registrar's Signature	600 North Wolfe	St, Baltimore, MD, 21287
	Sta Registr		MAY 1 1 2011		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month [□]2011 Nancy Lee RENNER 7:00 AM 7, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 260 Frederick Street Washington Hagerstown Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Hours 73 Yrs. 214-34-9961 July 4, Year 937 Maryland Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 260 Frederick Street 21740 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify. white 3 Widowed 4 Divorced Specify. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) housekeeping hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ Russell Ragland Goldie Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13064 Hoosier Court, Hagerstown, Maryland Ronnie Renner - son 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State Rose Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) May 10,2011 Hagerstown, Maryland 21. Signature of Funeral Service Minnich Funeral Home 22. Name and Address of Facility 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events and resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death be detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? certificate Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 1 🗌 Yes Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this ompleted filled in by the funeral 27. Manner of ath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ₩ Tatural 5 Pending injury 1 Yes 2 No Accident Investigation Could not be within 24 hours after deat To the Funeral Director: 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determine City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 2011

Registrar

State

Year.

VITE 143. HAGENSTON

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05/01/2011 Year MARTIN PAUL REISER 6:35 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Potomac 7 Arlive Court 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Hours (Month, Day, Year) 04/10/1931 **Director** Germany 80 383-44-7822 Usual Residence of Decedent 10a. State 10b County filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Potomac Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20854 7 Arlive Court 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University of Health and Mental Hygiene. tem 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Marvland 5+ Professor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be Emma Kofer August Reiser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Arlive Court, Potomac, MD 20854 Inge Reiser/wife item 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o þ cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05/03/11 Hanover, MD Cremation Sv 21. Singlure of Funeral Service Licens 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 14 years Physician, Cirrhosis of the liver disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner decades Chronic hepatitis C Sequentially list conditions, Examine cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events tran-Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical Division of Vital Records, P.O. Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death page 2 should be detached g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by C dificile colitis 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 ANo 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 1 XNo Other: 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 KResidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred XNatural 5 Pending injury ___vatural
☐ Accident
☐ Suici 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

filled in by T

> State Registrar

only one)

30. Name

Signature and title of certifier

31. Date filed (Month, Day, Year)

0 4 2011

ess of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

05/02/2011

14955 Shady Grove Road, #150

Rockville, MD 20850

29c. License number

D40154

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Julia Korenman, MD

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State		State	of Mary			artment of H		nd M	lental Hy	giene	9			
		Registrar 1. Decedent's Name	e (First, Middle,	Last)			Cer	tificate of D	<i>eath</i>		2. Date of Dea	Reg. No	<u>•5 Û</u>		3 Time	of Death
Physicia: Medic				TZWILLIA	M TERI	RY REI	STE	R			April	30	ay 20	0 Year	9:0	
Examin		4a. Facility Name (if 10395 Fo		give street and nu				4b. City, Town, or New Mai	_	Death		40		of Death	·k	
Funeral Director	, v	5. Social Security No. 216-34-7	umber	6. Sex 1 X M 2 □ F		yrs. last birth	nday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours		8. Date of Birt June 12	h , Year)	938	9. Birth	place (State	e or Foreign
	L	Usual Residence of 10a. State			110	c. City, Town	01 00	ation								City Limits
permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	Maryland	Frede	rick		New Ma		t							1 🗆 🗅	Yes 2 X No
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permit Depart Impor any in		21. Signature of Fu	neral Service Li	censee)			RÖ 12	BERT nd Addres 01 NORTH	SATLEY MARKE:	& Γ S'	SON FUN	ERA] FREI	L HOI	MES, CK, M	P.A. D 217	701
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	by	Part II. Other signif	ficant condition	ns contributing to	death but h	ot resulting in	the fu	nderlying cause giv	en in Part I.		23e. Did to					of death?
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To the Hospital or Attenwithin 24 hours after deat To the Funeral Director. completed filled in by the	Medical	(Check 2	Medical E	xaminer: On the ba	asis of exam	ination and/or	r invest	occured at the time, igation, in my opinio leath occurred at the	n, death occu	ırred at	the time, date a	nd plac	e, and du	e to the ca	use(s) and	manner stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 4:45 Рм Coburn Richardson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico 532 North Main Street Hebron Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Country) Idaho Months **Director** 450-30-4287 84 Usual Residence of Decedent 10a. State 10b. County items 23a or 28a-r sno ner must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 X Yes 2 No Wicomico Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 532 North Main Street 21830 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ò Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: WWII White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Walter Reed College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Research Microbiologist <u>Medical</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Elmer Coburn Wilma Lucille 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Richardson - Wife North Main Street, Hebron, Maryland 21830 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 5-2-2011 Delmar, Delaware Signature of Femeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home Salisbury, Maryland Main Street, 21804 23a. P. 1. Enter the disease, or cour lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Intraventria Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Fibrillahon Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hypertension this certificate has autopsy To the Hospital or Attending Physician: The within 24 hours after death. performed 1 Yes 2 No Be (Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 XX Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending ☐ Accident 1 ☐ Yes 2 ☐ No Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

'NX

State Registrar

Medical

29a. Certifier

(Check

only one

Signature and title of certifier

3 2011

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of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amended item #5 per fh Certificate of Death cchd ajs 5/12/11 Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Thelma R. Schmick 2011 0545 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death lalbet Hospital Memorial If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year Months Hours 1 □ M 2**X** F Min. Days Maryland 78 Yrs Director Feb. Usual Residence of Decedent or 28a-f show notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Preston Caroline MD 1 Yes 2 No 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Funeral 21655 United States 115 Williamson Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, · Schmick Armed Forces? Black White etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed 15 Decedent's Education Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Foster Mother Child Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Benjamin Dilworth Annie Estella Robertson he (ma 19a. Informant's Name/Relationship (Type, Print) Glenn E. Schmick/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Fastern Sh. Veterans Cem. 05/10/11 1 XBurial 2 Cremation 3 Removal from State Hurlock, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. Signature of Funeral Service Licensee Muhal 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) 122 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and -trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Pregnant at time of death 9 Unknown the P.O. ed by t signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 Tes page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy 1 ☐ Yes 2 ☐ No Vital in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 No Inpatient 2 ER/Outpatient 3 DOA 잍 4 Nursing Home 5 Residence 6 Other (Specify) this jo 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Division death. 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death
To the Funeral Director: ,
completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAShigton St. W. Morte wis 219 South 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0852 AN 20 /Pa Frances F. Smith Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 04 18 1 M 2 X F Months Hours Min. 217-56-1856 **Director** 81 930 Waynesboro, Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Washington 1 Yes 2 X No Smithsburg 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13322 Greensburg Rd. 21783 US items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black White etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give "natural", 3 ☐ Widowed 4 ♣ Divorced white Specify. Completed Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) cleaning publishing co Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clayton Triesh Susie Stull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susie A. Smith-Clipp 1419 Howell Rd. Hagerstown, MD 21740 20a. Method of Disposition

1 💆 Burial 2 🗌 Cremation 3 🕱 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 and Department of Hamportant: If ite 4 Donation 5 Other (Specify) Quincy Cemetery May 16, 2011 Quincy, PA e of Funeral Service Licensee Grove-Bowersox Funeral Home, 22. Name and Address of Facility 50 S. Broad St. Waynesboro, PA 17268 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ disease or condition resulting in death) 5day Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No signed by the a d be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗆 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 🙀 No Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No INDATION 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending Natural work? 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

the

State Registrar (Check

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year

30. Name and address of person who completed cause

death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

mull

Michael Bernard Simpson	Michael	Bernard	Simpson
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	1- For State Certificate of Death Reg. No.	
Physician/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	ne of Death 518 hrs
Medical Examiner	Michael Bernard Simpson	101115
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 37435 Asher Road 4c. County of Death St. Mary's	
Funeral		(State or
Director	5. Social Security Number 215-56-9610 6. Sex 17. Age (In yrs. last birthday) 60 Yrs. 6	snington. DC
·····	Usual Residence of Decedent	
/ any	Too. State Tob. County Toc. Sity, Town of Escation	Inside City Limits Yes 2 X No
faryland 184 once. Octor	1141/1414 000 1141/0	Tes 2 Zino
the Maryland a or 28a-f sh tified at one Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
th the 23a or notific	37435 Asher Road 20659 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Inc.)	dian Black
er death with t , or items 23s r must be not Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Inc. White, etc.	
", or er de		te
ours aft	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	у
5-0036 Ed within 72 hour stygiene state than "natu the Medical Exam Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Systems Controller Steamfitters	Union
oo3 withir jene. Medi	1 Systems Controller Steamfitters 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	OHIOH
215-0036 be filed within 7 mind Hygiene riked other than eat, the Medical Be Complé	William A. Simpson Oral L. Hill	
212 nould be d Ment is mark tic even	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co	
MD and 2 sho alth and and 27 is aumati	Deborah Simpson/Wile 3/435 Asher Road, Mechanicsville, MD 20059	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Brinsfield—Echols Crem. 20b. Place of Disposition (Name of cemetery, crematory or other place) Brinsfield—Echols Crem.	
Page nent o		
Baltimore, pernit. Pages I ar Department of Heimportant: If ite minjary or other trial	22. Name and Address of Facility Frins 1eld-Echols F.H., 30195 Three Notch Rd., Charlotte Hall,	
Physician	23a Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart App	proximate Interval
/Medical	failure. List bolly one cause on each line.	tween Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atheroscierotic Cardiovascular Disease Due to (or as a consequence of):	
ř .	Sequentially list conditions, b	
ted I Insit Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Jause C.	
, xam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
760, icate be executed physician and the burial - transit	d.	
'60, ate be execut obysician and ne burial - tra	UNPENDED AMENDED 23d. If we cultome of pregnancy 23d. Date of delivery	
876 tificate ng phy as the	The Females 230: If yes, outcome of pregnancy	Year
Box 687 e death certific the attending p ted for use as the	4 Pregnant at time of death 5 Other (Specify)	
). Box 687 the death certifin by the attending ched for use as t	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause given in Part II.	ause of death?
P.O. s that gened by e deta	Chronic alcohol abuse 1 ✓ Yes 2 No 3 Probably	4 Unknown
Records, The law requires fiteate has been sig page 2 should be Completed	24a. Was an 24b. Were autopsy autopsy prior to comple	findings available etion of cause of
e law re e law re e law re e has b	eatitysy performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	2 \ \ No
Lifficat or, pag		
Vital ysician ysician directo		ne
of Vital Records, P.O. B ing Physician: The law requires that the d After this certificate has been signed by the tuneral director, page 2 should be detached on: To Be Completed by Phy.	27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred	
Sion Attendi death. ctor: A	1 V Natural 5 Pending 1 Yes 2 No	
Division of Vital Records, P.O. spital or Attending Physician: The law requires that the tours after death. seral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be deated Certification: To Be Completed by P	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Ro or Town, State)	oute Number, City
ospita hours y fille		
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/	(Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and maintened as stated. Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and maintened as stated.	se(s)
To T	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Date signed (Month), Date sign	Day, Year)
	May 6, 2011	
0	30. Name and address of person who completed cause of death (Item 23a)	
Vet eme	Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
\$tate Registra		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2<u>011</u> 5:50a Physician Schelle Marie Mae May 5 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Golden Living Center Hagerstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 7-9-1915 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 215-36-6822 1 ☐ M 2 ☐ XF 95 PÃ Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD Washington Hagerstown 1XTYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 U.S.A. 750 Dual Highway Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white Maryland 21215-0036 1 ☐ Yes 🎾 No Specify þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) residence College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Calvin Faith Cora Grace Sword 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 420 Overhill Dr. Chambersburg, PA 17201 Gloria Eyer daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 5-9-2011 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Clear Spring, Rose Hill Cem 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc MD 21722 P.O.BOX 310 Clear Spring, 23a. Part1. Enter the disease or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or a 2 consequence of): **Physician** hum 54 eas /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death cortificate be executed attending physician and Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No 4□Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown signed by t if be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2√2 No 24a. Was an page 2 s certificate has autopsy performe **2√2** No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: A Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No Hospital: 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ဥ After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and addres person who completed cause ath (Item 23a) (Type, Print) Joth 3 D SMAIP 368 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 11:25 a M Carolyn Semler May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Smithsburg Washington 109 Joel Circle If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 X F Director 219-66-2406 56 3/31/195 New Jersey Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 ¥ Yes 2 ☐ No Washington Smithsburg 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral 109 Joel Circle 21783 U.S.A items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Examiner Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Completed Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Government 12 Program Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Kennedy Dorothy Robert Francis Collinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Joel Circle, Smithsburg, MD 21783 Keith Semler / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Smithsburg_Crematory 5/7/2011 Smithsburg, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ x many disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) by the signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 X10 3 Probably 4 Unknown cate has been signated to page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

JW-3

State Registrar (Check

only one

29b. Signature and title of cert

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination allows investigation, it in journal of the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

ay

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician/ Snyder Gail Joan 2011 7:44 Α Anri Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Allegany Allegany Health Nursing & 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 02/17/1940 Min 1 M 2 7 F Pennsylvania Director 177-32-8526 Usual Residence of Decedent 28a-f show 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County the Maryland Examiner must be notified at Director Cumberland 1 XYes 2 No MD Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 Funeral USA 23a 21502 hours after death with 440 N. Centre Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Black White etc. 9 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify "natural", White 3 🛚 Widowed 4 🗆 Divorced Year or Dates traumatic event, the Medical 16a Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene.
7 is marked other than "n (Specify only highest grade completed) 72 College (1-4 or 5+) Elementary/Seconday (0-12) Beauty Shop Beautician 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown ည Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 105 Hanover Street, Cumberland, MD permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Virgil W. Parsons / Companion 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Dremation 3 Removal from State Cumberland, MD Cumberland Crematory 04/29/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, F.A. 21. Signature of Funeral Service. Li 21502 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic Obstructive Pulmonary Disease Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Emphysema Sequentially list conditions. Examine Due to for as a consequence of: n any, leading to immediate cause. Enter Underlying as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 XNo Month Year ō Day Pregnant at time of death cate has been signed by the page 2 should be detached 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performe 1 Yes 2 No To the Funeral Director: After this certificate completed filled in by the funeral director, pag Yes 2 X No To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 2 X No 1 Ves ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 5 Pending 1 X Natural 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R137604 April 25, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Denise Wilson, CRNP, 730 Furnace Street, Cumberland, MD 31. Date filed (Month APR"2 9 201 32. Registrar's Signature State parked Registrar

				Please	State of M							egible.	
			For State Registrar			arylan		tificate of l	Health and I Death		Reg. N2		16196
	Physicia Medi		ZION		IKOLE		SHA	w - W1.	SE	2. Date of De Month APRIL	ath Day 25	Year 2011	3. Time of Death 12:45 M
1	Examir	ner	4a. Facility Name (in SHADY GR	. 0	e street and number) NTIST HO	SPITA	16	4b. City, Town, o	r Location of Death	1		unty of Death	OMERY
	Funeral Director		5. Social Security N none	lumber 6. S	Sex I □ м 2 Д F	e (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da APRIL		9. Birtl Cou	hplace (State or Foreign Intry) RYLAND
	show dat	tor	Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	or 28a-f	Funeral Director	MD 10e. Street and Nu	Montgome mber	ery	Pot	omac	10f. Zip Code			10g, Citizen	of What Cor	1X Yes 2 □ No
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980	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at	by	11. Marital Status	ried 2 🗆 Married	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.	Ever in U.S No		Vas Decedent of H f Yes, specify Cuba □ Yes 2 X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		Race - Amer Black, White	
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2	nd 2 should ealth and In 27 is mainer trauma		India Sh	ame/Relationship (aw/mothe)	ral Route Numbe Potomac			Code)					
Baltimore,					Removal from State	, ce	emetery, cren	sition (Name of natory or other place leaven Ce	- 1	Date 02/11		on-City or	Town, State
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Fu	ineral Service Licen	See Tura	ss of Facility Si shington							
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	d nted	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated event	linjury	Due to (or as	a Consequ	जारिक टॉंगु:						
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of Vital Records,	v requires the been signed should be contact.	Completed								1 🗆 1			obably 4 Unknown opsy findings available
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ion	tending leath. tor: Afte the fun	Certificate:	1 Natural 2 Accident 3 Suicide	5 ☐ Pending Investigatio 6 ☐ Could not I	ne l		injury		<br Yes 2 ☐ No				
Division	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completed filled in by the fu		4 🗌 Homicide	determined	28e. Place of Inji building, et	c. (Specify)		eet, factory, office		City or Tow	n, State)		al Route Number,
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	vitl To		29b. Signature and	title of certifier	16			DOO -	e number 71205	1	29d. Date sig APRIL		
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ZION NIKOLE SHAW WISE APRIL 25 2011 12:45HR

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 25 per dr., g915,05/15/2011dhb Certificate of Death For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Apri 5:15 PM Amos Allen Sharpe, Jr. 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Birthpiec Country) PA **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min. 01/27/1943 68 Yrs. Director 181-32-2206 Usual Residence of Decedent 23a or 28a-f show "natural", or items 23a or 28a-1 snoting 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21812 Mt. Aetna Road 21740 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, marked other than "natural", or itel Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 2 Investigator Federal Government Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hw.
Important: If item 27 is mariany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Shirley Troutman Amos A. Sharpe, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas M.Sharpe/Brother 8604 Norfolk Avenue Annandale, VA 22003 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 05/05/2011 4 ☐ Donation 5 ☐ Other (Specify) Damascus Cemetery Big Cove Tannery, PA 21. Sonature Funeral Service Licen 22. Name and Address of Facility 141 West Main Street MOO260 Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ANCE Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Day Year 4 ☐ Pregnant at time of death g ☐ Unknown ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate 1 Yes 2 No Yes Hospital or Attending Physician: 24 hours after death. within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗶 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Manner of Death 1 Natural 28c. Injury at work? Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury Accident Suicide 2 No Investigation 1 Yes 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and tit 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21742

State

Registrar

19

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Philip Dominic Torello Medical a. Facility Name (if not institution give street and number Examiner 4c. County of Death SURNIE NRO Social Security Number 6. Sex 1 **XX**M 2 □ F **Funeral** 7. Age (In yrs. last birthday If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Min. Hours 041-24-6023 79 8 8 1 9 3 1 ar Country) **Director** Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel 0denton 1 Yes XX No 10e. Street and Number ò 10f. Zip Code 10g, Citizen of What Country? Funeral 23a 503 Williamsburg Lane 21113 USA items ? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. ō þ 1 Never Married 2XXMarried 1XXYes 2 No Baltimore, Maryland 21215-0036 White and 2 should be filed within 72 hours aft Health and Mental Hygiene. tem 27 is marked other than "natural", If Yes, Give Year or Dates, Vietnam 1 Yes 2 No Specify: 3 Divorced 4 Divorced Specify Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Analyst NSA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Philip Torello Nicolina Milano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Joan Torello Wife 503 Williamsburg Lane Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State Atlantic Crematory 5/6/2011 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ 54wct septie disease or condition Medical resulting in death) Examiner Stage disease renal Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Cardiomyo or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events path and Due to (or as a consequence of resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
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To the Funeral Director: After this certificate Yes 2 X No 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 XYes 2 No Certificate: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending injury 2 No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1) 21225 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+ Lein M-D 6len 208 landnark 4122 2106

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month

4 2011

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 3. Time of Death Physician/ Paul Louis Torpey 8:26 am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Doctors Community Hospital Lanham If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 € M 2 □ F Days Hours Min. May 8, 1932 577-44-3288 78 Yrs. Washington, DC **Director** Usual Residence of Decedent 28a-f show 10a. State 10b County aţ 10c. City, Town or Location 10d. Inside City Limits Director Maryland Greenbelt notified Prince George's 1 Yes 2 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 6204 Springhill Drive, #304 20770 United States items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Koroom I. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White "natural" 3 Widowed 4 Divorced Specify Completed It Yes, Give Year or Dates K**orean War** Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) alth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med College (1-4 or 5+) Elementary/Seconday (0-12) Librarian P.G. County filed \ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas John Torpey Catherine Ummerle 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, Joan T. O'Donnell -sister 13012 Elkridge Street Beltsville, Maryland 20705 20a. Method of Disposition
1 Amount 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Fort Lincoln Cemetery 5/7/2011 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Bonald Avess Bongwardt Funeral Home, PA V130 ald 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner pertensi Sequentially list conditions Physician/Medical Examiner if any leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burid Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Yes 2 9 Unknown ed by the a 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate Yes 2 1 Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 2 [1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) Manher of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide М Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centrying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) To the I within 2 29b. Signature 10+1 e and address of person who completed cause of death (Item 23a) (Type, Print) 8118 MAY 0 4 2011 Registrar

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Examin Funeral	er	4a. Facility Name (if not institution Vindobona Nurs 5. Social Security Number	sing Home	e (In yrs. Ia	ast birthday)	11		hts Hrs. 8. Date of Bi	rth	y of Death ederic 9. Birthpl	lace (State or Foreign
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with the Mar s 23a or 28a ust be notifi	eral Dire	10e. Street and Number 5860 Genesis				10f. Zip Code 217(10g. Citizen of USA	What Count	1 ☐ Yes 2¾X No
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Mar 3 □ Widowed 4 □ Divorced	15 1/2 = 0:	Ever in U.S No I nkn o	"	Vas Decedent o Yes, specify Cu	iban, Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)		ce - America ck, White, et wh	
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To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physi completed filled in by the funeral director, page 2 should be detached for use as the I.	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	I death 3 🗌	Ectopic pregna Other (specify)				ate of deliver	'Y Day Year
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15		30. Name and address of person v	$\frac{7}{2}$ $\frac{7}{2}$ who completed cause of de $\frac{7}{2}$ $\frac{7}{2}$	eath (Item	23a) (Type, Pr	int)	L HOU	15E -H	MHY	FRF.	ed. ay, Year) 2, 2011 DERICK
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2011 **Physician** George Clark Tome May 0625 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Davs Hours Min 1 € M 2 🗆 F 218-54-0712 59 Director 1, 1951 Maryland Dec. Usual Residence of Decedent show 10b. County 10c. City. Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Macical Examinar in 1st by 10, Illied at TY∐Yes 2∐No Director Maryland Cecil Perryville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 13 Brookside Drive 21903 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify. þ White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Onguard Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Belcamp, Maryland Ten Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental h Christopher Daniel Tome Gladys M. Grove ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau Jacqueline Hodges (wife) 13 Brookside Drive, Perryville, Maryland 21903 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Shenberger 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/10/11 4 ☐ Donation 5 ☐ Other (Specify) Red Lion, Pennsylvania Chapel Cemetery Lee A. Patterson & Son Funeral Home, P Perryville, Maryland 21903-0766 21. Signature of Funeral Service Licensee Thomash tallenan Sc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CARDIAC resulting in death) /Medical Due to (or as a consequence of) Examiner HYPER KALEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and physician al Due to (or as a consequence of) certificate be Physician/Medical as IE FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached to Tyes 2 No 9 \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No ACUTE RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Vital 2 [1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only onle) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,

completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0069118 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. UNION AVE HAVRE de GRACE, MD 21078 3

Registrar

State

31. Date filed (Month, Day)

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EORGE

,MD

32. Regis ar's Signature

UTHAWALA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 7 (200 1. Decedent's Name (First, Middle, Last)

Jane F. Tu 2. Date of Death 3. Time of Death Túcker Physician/ Month 2ŎĨ) May 2 3:15 ď Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Min. 1 M 2 X Hours 0*%%*13%1950 MaryTand Director 217-54-5542 60 Usual Residence of Decedent if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland πent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Worcester Berlin 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 12355 Sinepuxent Road 21811 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Program Manager Television Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Virginia E. Larmore William H. Fooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara Hudson/daughter 12355 Sinepuxent Rd., Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State 5/5/2011 4 Donation 5 Other (Specify) Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service Licens Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Attending Physician: The law requires after death. 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Division of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 🗹 Natural 5 Pending 2 Accident
3 Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date.signed (Month. Day, Year) TE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DUNKIN

Registrar

State

31. Date filed (Month

DOB: 7

		-	For State Registrar	State of M	aryland .		artment of I			giene Reg. No.	2011	5	204
	Physicia Medic		1. Decedent's Name (First, Middle, L. Gladys	ast)	The	omas			2. Date of Dea	ath Pay	2011	3. Time of D 3:40	
-	Examin		4a. Facility Name (if not institution, gi 2601 Keith Str	,			4b. City, Town, o	r Location of Deat H ills	h		County of Death	rge's	
	Funeral Director		241-40-5141	Sex 1 □ M 2 🔀 F	e (In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9 ^Y 138		olace (State or fryMount	
	Maryland 28a-f show notified at	Funeral Director	Usual Residence of Decedent 10a. State DC 10b. County		10c. City, To		of Colum	lbia				0d. Inside City	
	with the s 23a or lust be r	eral [10e. Street and Number 2309 Savannah S	treet SE			10f. Zip Code 2002	.0		_	ten of What Cour ted Stat	-	
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates.			Was Decedent of F f Yes, specify Cuba I Yes 2 K No		pecify Yes or No- o Rican, etc.)		4. Race - Americ Black, White, Specify: B1a	etc.	
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Maryland 2	I be filed wit Mental Hygie Irked other Ic event, th	To Be C	12 17. Father's Name (First, Middle, Last Mingo Ward)		Dieti	lcian	18. Mother's Na	me (First, Middle, Smith		ews Air urname)	Force	base_
, Mary	nd 2 should saith and M n 27 is ma er trauma		19a. Informant's Name/Relationship Sharon Dew (Gr		r) 2	19b. Mailir 601 I	ng Address (Street Keith Str	and Number or Ru	ral Route Numbe ple Hill	r, City or 7	own, State, Zip 0 D 20748	Code)	
Baltimore,	Page 1 ar ment of He ant: If iten ury or oth	N 39	20a. Method of Disposition 1	☐ Removal from State		etery, cren L in o	sition (Name of natory or other place oln Ceme	etery	D/2011	Bre	ntwood,	MD	
Balt	permit. Departi Import any inj		21. Signature of Fureral Service Lige	mp 4		22	. Name and Addre	ss of Facility Fo	rt Linco Road E	oln F Brent	uneral Mood, M	10me) 20722	
	Physician/ Medical Examiner	ər	23a. Part 1. Enter the discusse, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Concest Due to (or as	cive He	eart ce of):	er the mode of dyir Failure yothapy	ng, such as cardiad	or respiratory an	rest,		Approximate Interval Betw Onset and De years	een
092	cate be executed physician and the burial-transit	edical Examiner	Equaritiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	,	sclerot	tic c	ardiovas	cular di	sease			years_	
. Box 6876	The law requires that the death certificate tate has been signed by the attending physipage 2 should be detached for use as the t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal de	eath 3 🛚	Ectopic pregnan Other (specify)	су		2	3d. Date of deliv Month		ear
s, P.O.	v requires that the second of		Part II. Other significant conditions Cerebral Vascul	-		ng in the u	inderlying cause gi	ven in Part I.	23e. Did to		e contribute to to		
Record	The law requarte has been page 2 shou	Completed by	Chronic Kidney	Disease					24a. Was autop perfo 1 ☐ Yes		24b. Were auto prior to co death?	mpletion of ca	/ailable use of
tal	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			26. P	lace of Death (Che	ck only one)				l a
of V	g Phys er this c eral dir	e: 10	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpati	ent 2 ER ry 28	b. Time of	28c. Inju	y at	dome 5 Resid		**	Resid	ence
Division of Vital Records,	or Attending Physician: after death, Director: After this certific in by the funeral director,	Certificate:	1 XX Natural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be 280 Place of Init	ıry - At home	injury , farm, str	M 1 C	k? Yes 2 ☐ No	28f. Location (S City or Tow	Street and vn, State)	Number or Rura	Route Numbe	»r,
	To the Hospital or Attend within 24 hours after deati To the Funeral Director: completed filled in by the	Medical	(Check 2 ☐ Medical Exa only one) 3 ☐ Certifying No	nysician: To the best of miner: On the basis of e urse Practioner: To the	xamination an	ıd/or inves	tigation, in my opini death occurred at th	on, death occurred ne time, date and pl	at the time, date a ace, and due to the	ind place, e cause(s)	and due to the ca and manner as st -	use(s) and man ated.	ner stated.
0	To			1 Willia			<u> </u>	8032			signed (Month,	Day, Year)	
R	-6		30. Name Md address of person who Cynthia M. Wil	completed cause of d	eath (Item 23	a) (Type, F	on Street	: NW Was	hington,	, DC	20016		
T.	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ May 8, 2011 1835 Dailev Timbrook М Robert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Allegany Health Nur. & Rehab. Ctr. Cumberland Allegany If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Min. Sep 21 Director 82 234-38-9164 28a-f shov 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director MD Allegany Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 730 Furnace Street 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 2 1 Never Married 2 Married Maryland 21215-0036 hours after 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 X Divorced Specify. Completed white the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) The American Iron & Metal Co. 12 torch burner permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Minnie (Loy) Timbrook Phillip H. Timbrook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code MD 21502 Larry Timbrook PO Box 304 son Cumberland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20c. Location - City or Town, State 1 Burial 2 Tremation 3 Removal from State 5/9/2011 MD Cresaptown 4 Donation 5 Other (Specify) Sinatury of Funeral Service 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or asia consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 2 No 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2/No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autops Division of Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniurv 5 Pending work? 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title 29d. Date signed n who completed cause of death (Item 23a) (Type, Print) filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ ROBERT MICHAEL VARKONDA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Western MD Regional Medical Center Cumberland Allegany 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
West Virginia Months Hours Min. 10/03/1948 Director 234-78-5541 62 Usual Residence of Decedent 28a-f show 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director WV Mineral 1 Yes 2 X No Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Parks Lane 26726 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry I Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th Shipping Clerk Hunter-Douglas Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Paul Varkonda, Sr. Elizabeth Ann Liebiecer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Deborah Varkonda / wife P.O. Box 933, Ridgeley, WV 26753 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 😾 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory | 05/04/2011 Cumberland, MD 22. Name and Address of Facility Upchurch Funeral Home, 21. Signature of Funeral Service Licensee 202 Greene Street, Cumberland, MD 23a. Part 1. Enter the "sease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical (or as a consequence of Examiner oronari JREUMS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year ed by the a 9 Unknown Unknown that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hyperlipidemia 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician; The law Jas performed 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: ၉ 1 🗌 Yes 1 Inpatient 2 SER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Matural Natural 5 Pendina work? within 24 hours after death.

To the Funeral Director; A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records, P.O.

Division of Vital

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B1. Date filed (Month, Day, Year)

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Examin		4a. Facility Name (if Western		-	,	ıl Cei	nter	4b. City,		Location of Death		4	c. County	of Death		
Funeral Director		5. Social Security N 218-16-2		6. Sex 1 \(\text{M} \) 2 \(\text{L} \)	7. Ag	ge (In yrs. la	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi			9. Birthr	olace (State o	or Foreign
nd now at	Ē	Usual Residence of 10a. State	Decedent 10b. County			10c City	y, Town or Lo	cation				,,,,,			Od. Inside Ci	itu Limita
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s 23a or	Funeral Director	10e. Street and Nun 128 A	nber .rch St	reet				10f. Zip	Code	2150	2	10g. C	Citizen of V	Vhat Cour US		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 ☐ Never Marri 3 ☑ Widowed		ried Armed	Forces?		1	Was Deced f Yes, spec	ify Cubar	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)			e - Americ k, White, e	etc.	
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Physician/		23a. Part 1. Enter t shock, or hear Immediate Cause (disease or conditio	rt failure. List o Final	complications the only one cause or	at caused each line	d the death e.	n. Do not ente	er the mode	of dying	, such as cardiac o	or respiratory a	rrest,			Approximate Interval Bet Onset and	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medica	23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	nonths?	4 🗆 P	ive Birth		I death 3	Ectopic p Other (sp		/		į	23d. Date Mor	e of delive		/ear
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Hospital	Medical ((Check 2		xaminer: On the	basis of e	xamınatıon	and/or invest	igation, in n	ny opinior	date and place, an	the time, date a	and place	e, and due	to the cau	ıse(s) and mar	nner stated.
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Registra	ar	MA	Y 0 4 2	011	wa	A.	frank	20								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 23a, 28d, per me, g916, 6-6-11 sm State of Maryland, Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 30 20 /Yea Physician/ 5 M 8 V/m ha Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death F 426 No, 74 Summi Hersbur Mond 91 102 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 8. Date of Birth 1 🛛 M 2 🗆 F 220-84-5471 (Month, Day, Year) 09/22/1968 Country Director MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Montgomery Gaithersburg 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 USA 428 North Summit Drive, #102 death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. and Mental Hygiene. is marked other than "natural", or 1 X Never Married 2 ☐ Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give 3
Widowed 4 Divorced Specify: Black Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Refuse Collection Al's Refuse Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Kenneth Wilkerson Darlene Addison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Michael Wilkerson, 19819 Mayhill Terr., Gaithersburg, MD 20879 Jr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Svc: 05/03/11 Hanover, MD Signature of Funeral Service License 22. Name and Address of Facility Snowden Funeral Home 32V 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart rilure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Intraoral Shotsun Wound Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year been signed by the a should be detached to 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law page 2 s certificate has autopsy performed? Yes 2 No death? within 24 hours after death.

To the Funeral Director. After this certific.

Gompleted filled in by the funeral director. I of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1. Yes Hospital: Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred subject shot self 1 Natural 5 Pending work? 1 ☐ Yes 2 No 1115 Accident Investigation Apr 30 2011 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number Homicide determined City or Town, State) 428 Nome mp Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) a date and place, and due to the cause(s) a date and place, and due to the cause(s) and death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and place at the time. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To me best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 00728 MIR M mo Ome 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Brecher $M \cdot D$ 524 Hawkesbury Lane; Silver Spring, MD 20904 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 4 2011 Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death Physician/ Frederick James Wueste Sr. 28 2011 5:10 April Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Wicomico Nursing Home Salisbury Wicomico Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs, last birthday 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Days Hours 076-10-8034 Months Min. 1070571912 Director 98 Texas Usual Residence of Deceden ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d Inside City Limits Director 1 X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Numbe 10f. Zin Code 10g. Citizen of What Country? Funeral 1109 S. Schumaker Drive 21804 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ld be filed within 72 hours after of Mental Hygiene. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 and Mental Hygiene. is marked other than "natural", If Yes, Give 1 Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Engineer Electricity 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elsie Hines Leo Wueste permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print)
Martha McLaughlin/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5363 Royal Mile Blvd., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5/2/2011 Salisbury Crematory Salisbury, MD 4 Donation 5 Other (Specify) ture of Funeral Service Licensee HOTTOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Morroson CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Vear the hed t signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ᇫ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of pause of 24a. Was an cate has l autopsy performed death? certificate 2 1 No 1 A Yes Yes 2 N 25. Was case referred to medical Certificate: To Be 26. Place of Death Check only one) examiner? 1 Yes Other 1 Inpatient 2 ER/Outpatient 3 DOA this 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at eral Director: After filled in by the funer 28d. Describe how injury occurred work? atural 5 Pending 2 No Accident
Suicide
Homicide Investigation ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioners To the best of my knowle at the films, date and State to did due to the a causals) and main ar as state of certifier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 6m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahesha Thimmarayappa MD 910 Easternshore Dr Salisbury MD 21804

DHMH 17 Rev 7/2009

State

Registrar

32. a gistrar's Signature

2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRIL 2011 Patricia H. Wilder 9:50 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Chever1y Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Days Months Hours Min. 02/24/1943 Country) 238-70-6256 Director 68 NC Usual Residence of Decedent 28a-f show 10a. State filed within 72 hours after death with the Maryland aţ 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Examiner must be notified 1X Yes 2 No. MD Prince George's Mitchellville 6 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 915 Millponds Court 20721 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ þ 1 Never Married 2 Married Black, White, etc. 1 Yes 2**X** No 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural" Completed 3 Widowed 4 X Divorced Specify: Black Year or Dates Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Program Analyst Federal Government other Be 17. Father's Name (First, Middle, Last) i. Page 1 and 2 should be filec tment of Health and Mental H tant: If item 27 is marked ot jury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) 0 William R. Hargraves, Sr. Ruby Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Wilder/ Son 915 Millponds Court, Mitchellville, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Department o Important: If any injury or Harmony Cemetery May 6, 2011 Landover, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, Maryland 20747 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final ARDIAC Onset and Death Physician/ HATAL disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** STAGE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) ___ Pregnant at time of death Year Month Day signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No To the Hospital or Attending Physician: the Funeral Director: After this certificated filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: |₽ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Suicide Investigation 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

DHMH 17 Rev 7/2009

(Check

only one) Signature a

d title of certifie

DAV15

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MA

3001

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Marylan		artment of H		ivientai Hy	giene 2 N I	16211
			Registrar 1. Decedent's Name (First, Middl)	e. Last)		Cer	tificate of D	veatn	2. Date of De	Reg. No.	1021
	Physicia		Doris Elphin	-,,	Q				Month May 8	Day	3. Time of Death 9:30 p.mM
	Medic Examin		4a. Facility Name (if not institution		0		4b. City, Town, or	Location of Dea		4c. County of	
			Taylor Farms As		iving	_	Bushwood			St. Mar	ry's
	Funeral Director		5. Social Security Number 577-20-7582	6. Sex 1 ☐ M 2 ☐ X F	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			9. Birthplace (State or Foreign Country) irginia
	d iow it	_	Usual Residence of Decedent 10a, State 10b, County			ty, Town or Loc					
	arylan a-f sh fied a	Director									10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	or 28 or 28 e noti	Ę	Maryland St. Ma 10e. Street and Number	ary s	lcorr	ons Po	10f. Zip Code		I	10g. Citizen of Wh	
	with s 23a ust b	Funeral	20438 Riverview	, Drive			20626			United St	•
	death item		11. Marital Status	12. Was De Armed I	cedent Ever in U.S Forces?		Vas Decedent of His Yes, specify Cubar		Specify Yes or No-	14. Race -	American Indian,
336	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by	1 ☐ Never Married 2 ☐ Mar 3 🛛 Widowed 4 ☐ Divorced	ried 1 1 Ye	s 2 🛛 No Give		☐ Yes 2 🛛 No		,	Specific	White, etc.
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Maryland	be file lental I rked o rc eve	10	Asa Pinkard	_asij				Annie N		Maiden Surname)	
ary	and M and M is mai	44	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address (Street a			r, City or Town, Stat	e, Zip Code)
	ind 2 s lealth m 27		Connie Kahl/Dau	ighter		970 W	arner Dri	ive, Hun	tingtown	, MD 200	539
lore	ge 1a it of H : If ite or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation	3 Removal fro	om State 20b. F	Place of Disposemetery, crem	sition (Name of natory or other place	e)	Date	20c. Location - C	ty or Town, State
Baltimore,	nit. Pagartmer artmer ortant injury		4 Donation 5 Other (3	Specify)	Bri		d-Echols				e Hall, MD
Ba	Depar Depar Impor any ir	Į.	21. Signature of Funeral Service Danielle Ward	M01403	4 lle		. Name and Address	DI		Funeral	Home, P.A. MD 20650
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that	t caused the deat	h. Do not ente	r the mode of dying	, such as cardia	c or respiratory an	rest,	Approximate
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Baltimore, Maryland 21215-0036

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Funeral Director		5. Social Security Nu	None	6. Sex 1 ☐ N	1 2 X F	. Age (In yrs. 74		day) If Und Month	ler 1 Year s Days	If Unde Hours	er 24 Hrs. Min.	8. Date of B (Month, I May 1	irth Day, Year . 0 ,	g.	Birthp Cou <i>nt</i> K C	ilace (State or try) rea	Foreign
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Page 1 ar ment of He ant: If iten ury or oth		20a. Method of Disp 1	Cremation	3 ☐ Ren	noval from S	tate 20b.	Metr	Disposition (A crematory o DPOIIT matory	r o <i>ther pl</i> ac an		May 201	Date 5, 1	A1.	Location - City	а.		ia
permit. Depart Import any inj		21. Signature of Fur	neral Service L	icenfee	MO	Q 689		22. Name 10 Ea	and Addre	ss of Faci eer I	ellity De Park	Vol Fu	nera Gai	l Home; thersb	ırg	, MD 20	0877
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 7/2009

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Division of Vital Records, P.O. Box 68760

aula Mara Zuco	ca		ate of Maryla				-		gible.	
		1- For State Registrar		Cei	rtificate of	Death			eg. No. 20	16213
Physicia Medical Exami		Decedent's Name (First, Middle 1) Decedent's Name (First, Middle 1)						2. Date of Dea Month	Day Year	3. Time of Death 0500 hrs
MEGICAI EXAMII	ner	Paula Mara 4a. Facility Name (if not institutio		nber)	14	b. City, Town, or L	ocation of Dea	May 12, 2	4c. County of	
		7309 Baltimore Nation		,		Frederick			Frederick	
Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24H		rth (MM/DD/YYYY)	9. Birthplace (State or
Director		218-90-2989	1M 2XF	48	Yrs.	Months Days	Hours M.	in. 04/01	/1963	Foreign Washington Country) DC
b		Usual Residence of Decedent		140 -11			d			Land to the O's Live
w any	ĺ	10a. State 10b. County	1 1	10c. City,	Town or Location					10d. Inside City Limits 1 Yes 2 No
Maryland 28a-f show	호	MD Fre	derick		Freder	10f. Zip Code		14	Og. Citizen of Wha	
with the Maryland ms 23a or 28a-f sho be notified at once	Director	7309 Baltimo	ro Nationa	1 Diko		21702)		United	-
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5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	17. Father's Name (First, Middle,			Owner			ne (First, Middle,	Maiden Surname)	
21215-0(uld be filed wi Mental Hygien marked other e event, the M	Be (John N. Ph	illips				Kat	hleen Mu	ırphv	
e, MD 21215-0036 I and 2 should be filed within /2 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f she r traumatic event, the Medical Examiner must be notified at once	ို	19a. Informant's Name/Relations					and Number or	Rural Route Nur	nber, City or Town,	
MC all and all the am 27		John N. Phill	ips / fath		11424	Bedford	lshire	Ave., Po	tomac, M	D 20854 Dity or Town, State
Baltimore, permit. Pages 1 an Department of He Important: If ite		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal from	n State	crematory or oth			Date		
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Baltimore, MD 21215 pemit Pages I and 2 should be filed Department of Health and Mental Hy Important: If iten 27 is marked o injury or other traumatic event, th		21. Signature of Funeral Service	Licensee	MO122	22. No	ame and Address	of Facility Ke	eney & B	Sastord F	uneral Home
Physician	\dashv	23a. Part I. Enter the disease, or	complications that cau	used the death	. Do not enter the	e mode of dying, s	uch as cardiac	or respiratory arr	erick, MD est, shock, or hear	t Approximate Interval
/Medical		failure. List only one cause Immediate Cause (Final disease	on each line.Card a. Associa	iac Arı	rhythmia	due to	increas	sed Card	iacfibro	Sis Between Onset and Death
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3876 rtifica ing ph as the	2	23b. Was decedent pregnant in the past 12 months?				al death 3	Ectopic pregr	nancy	Month	Day Year
Box 68760, e death certificate by the attending physic ed for use as the bu	sici	1 Yes 2 No 9 ✓ Unk	T	nt at time of de	ath 5 Oth	er (Specify)				
the de cined f	Physician/Me	Part II. Other significant conditi	3 Olikiow		esulting in the un	iderlying cause giv	ven in Part I.	23e, Did to	obacco use contrib	ute to the cause of death?
ires that the signed by a signed by a libe detached	à	Chronic Alcol	•		-	,g g		1 Yes	s 2 No 3	Probably 4 V Unknown
rds, require peen si hould b	Completed	oni onic nicon	ior mode		·			24a. Was		ere autopsy findings available
e law e has l	E I							autop perfo 1 ✓ Yes	med? de	ior to completion of cause of eath?
tal Rectian: The		25. Was case referred to medical				26.Place o	of Death (Check		2 No 1	Yes 2 No
Vital Rec hysician: The I this certificate I	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inj	patient 2	ER/Outpatient		ther -		Residence 6	Other: Scene
1 of ling Ph After ti funeral		27. Manner of Death	28a. Date of (Month, D	f Injury Day Year)	28b. Time of In	ury 28c. Injury	at Work?	28d. Describe	how injury оссите	d
ion tendin eath. tor: /	atio	1 Natural 5 Pend 2 Accident Inves		,1:,		1 Ye	es 2 No			
Division of Vital Records, na or Attending Physician: The law requirers after death. The	Certification:	3 Suicide 6 Could	not be 28e. Place	of Injury - At ho	ome, farm, street	, factory, office bu	ilding, etc.	28f. Location (or Rural Route Number, City
Spital hours nearly filled		4 Homicide	mined (Specify)							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detactived for use as the buri	ical	(Check only Certifying Pri	ysician: To the best on the basis of	-	-					
To To Com	Medi	29b. Signature and title of certifie	and manner sta	ted.		29c. License	number		29d. Date signed	(Month, Day, Year)
2 10		1.10. 0.	and M	D		O.C.M	ı.E.		May 12, 201	1
nend	-	30. Name and address of person	who completed cause	of death (Item	23a)			<u> </u>		
P		Melissa Brassell, MD	Assistant Med	•	•	Baltimore Str	reet, Baltim	ore, MD 2122	23	
Sta		31. Date filed (Month, Day, Year)	32. Reg	istrar's Signatu						
Regist		MAY 1 S	2011 Con	man 1	w. Agran	Kel				
DHMH 17 Rev 1/20 OCME 2006	001	OCME	*	•	ORIĞINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death L Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edward Annen $\mathbf{P}_{\bullet}^{\mathsf{M}}$ 19 2011 7:38 May Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Robert Hooper Assisted Living Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**XX**M 2 □ F Months Davs Hours August 27 Baltimore, Maryland 216-24-3401 82 1928 Director Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland event, the Medical Examiner must be notified at Director 1 Yes 2XXNo Baltimore Parkville Maryland 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? United States Funeral items 23a 21234 2131 Pitney Road of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status rmed Forces? Black, White, etc. ö 1 Never Married 2 Married þ 1XXYes White 1 ☐ Yes 2XXNo Specify. If Yes Give Specify: "natural" 3 Widowed 4XXDivorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Baltimore, Maryland 212 Elementary/Seconday (0-12) College (1-4 or 5+) Manager Insurance Be 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental H Important: If item 27 is marked oft any injury or other traumatic mone. 17. Father's Name (First, Middle, Last) ည Ethel M. Martin Francis L. Annen, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 300 Colgate Drive Forest Hill, Maryland 21050 Michael Annen/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 23, 2011 1 M Burial 2 Cremation 3 Removal from State Parkwood Cemetery 4 Donation 5 Other (Specify) Parkville, Maryland 22. Name and Address of Facility
Evans Fineral Chapel and Cremation Services, Inc.—Parkville
8880 Hanford Road Parkville, Maryland 21234 21. Signature of Fundral Service 23a. Part 1 Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). Exami attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown s been signed by the s should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy 2 No certificate 1 🗌 Yes Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? 1 Tyes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred After iniury Natural 5 Pendina To the Hospital or Attendir within 24 hours after death.

To the Funeral Director, Af completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and ti rson who completed cause of death (Item 23a) (Type, Print) Name and andre 15X1 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 11:45M Physician/ May 201°1 Anna Belle Allen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Riverview Nursing Center Essex Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7 Age (In vrs. last hirthday) **Funeral** 223-42-2572 1 □ M 2 🛛 F Days Hours Min. 77 Director 1933 Usual Residence of Decedent 28a-f show 10a State 10b. County should be filed within 72 hours after death with the Maryland and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f sho ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Middle River 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 USA 1210 Susquehanna Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 ☐ Yes 2 ☐xNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 N Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Seamstress 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sew Biz 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Viands UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Page 1 and 2 sh partment of Health a portant: If item 27 is y injury or other tra 38185 Zane Court Mechanicville MD 20659 Beth Allen /daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important; If ite
any injury or oth 1 Burial 2 Cremation 3 Removal from State Holly Hill Cemetery 5/21/11 Baltimore MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (orangery andary We to Onset and Death Ku Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) burial-transi Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 month Pregnant at time of death been signed by the should be detached 9 | Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a Was an page performed? Yes 2 No 1 Yes 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital Other: |요 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work nours after death.

neral Director; Af
filled in by the fur 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) within 24 hours at

To the Funeral D

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and a missing summer of the basis of examination and summer as stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier me and address of person who completed cause of death (Item 23a) (Type, Print)

AALIHA WASEM. 70 9. MD -21221. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 15 Day 2011 Month MARJORIE ALBRECHT 12:15 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 Nov 19ay, Year 27 Months Days Hours Min. New Jersey **Director** 556-42-1518 83 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Frederick Adamstown 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 3200 Baker Circle 21710 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White Page 1 and 2 should be filed within 72 hours aft ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", If Yes Give 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) secretarial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marjorie Stutzer Martin Sidney Lindgrove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bronwyn Fannon - daughter 92 Clifford Ct; Harpers Ferry, WV 25425 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) gnau Funeral Service 22. Name and Address of Facility State Anatomy Board rector 655 W. Baltimore St; Balto, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
 or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner respiratory minutes Sequentially list conditions, if any, leading to immediate cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed days pneumania that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death signed by the a 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has b lirector, page 2 sh 24a. Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death

To the Funeral Director,

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MAY 15, 2011 MAA D 71319

State Registrar

DHMH 17 Rev 7/2009

Frederick, MD 21701

400 W 7th St.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carol Waldmann, MD,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2011 May 18 Silvia E. Burmeister 1:27 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10403 Windsor View Drive Montgomery Potomac Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth Days (Month, Day, Year, Hours Min 1 □ M 2 💢 F 577-90-4560 **Director** Yrs. 68 reb 13 1943 Germany Usual Residence of Decedent Show 10a, State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s rer must be notified MD Montgomery 1 Yes 2X No Potomac 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 10403 Windsor View Drive 20854 USA "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🏋 No 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Fitness Instructor YMCA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental item 27 is marked of ည Johannes Rosenbusch Elisabeth Mueller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) H. Harald Burmeister/Husband 10403 Windsor View Drive Potomac, MD 20854 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ō 1 Durial 2 K Cremation 3 Removal from State Important: If any injury or Final Journey Crematory 05/19/2011 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signa of Funeral Service License Going "Homes Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pancreatic Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has page 2 autopsy perform death? certificate 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 💢 Natural 5 Pending I hours after death.

uneral Director: After the function by the function of t 1 🗌 Yes 2 🗌 No Investigation 6 Could not be □ Accident ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D37142 May 18, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coleman, M.D. 1355 Piccard Drive #100 Rockville, MD 20850

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death BECKER Physician/ ROSS ELWIN Month Day 7:20 Medical 2011 MAY 6. 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery <u>2510 Holman Avenue</u> Silver Spring If Under 1 Year 8. Date of Birth
(Month, Day, Year)
Apr 11, 1924 7. Age (In yrs. last birthday) **Funeral** If Under 24 Hrs. 9. Birthplace (State or Foreign 087-22-9475 1 XM 2 🗆 F Months Days Minnesota **Director** 87 Usual Residence of Decedent shov 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Silver Spring Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral <u>2510 Holman Avenue</u> 20910 United States 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, med Forces? Black, White, etc. ģ 1 Never Married 2 Married 2 No Maryland 21215-0036 If Yes, Give Year or Dates. WW-II 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 12 Construction Painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Ross Becker Esther Hela 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau <u>2510 Holman Ave Silver Spring</u>, MD 20910 <u>Eda Winner / Daughter</u> Baltimore, 20a, Method of Disposition 20b, Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/18/2011 Final Journey Crematory Woodbine, Maryland of Funeral Service Li Signal 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Dille to (prasia nor sequence of) cause. Enter Underlying Examir Cause (Disease or linjury that initiated events the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year signed by the at d be detached fo Pregnant at time of death Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ATHEROSCLEROTIC CARDIOVASCULAR DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed ESSENTIAL HYPERTENSION Were autopsy findings available prior to completion of cause of 24a. Was an page 2 performed No death? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? P Other: 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify, After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 K Natural 5 Pending work 1 Tes 2 🗌 No hours after death the Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) 24 hours Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

3

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type Print Name and Address of Person who completed cause of death (Item 23a) (Type Print Name and Address of Person Name and Nam

MD# 33255

MAY 19, 2011

Patient known as Elmer Brown

				Pleas	se Type or Pr					-		Legible.	
			For State Registrar		State of IV	ıaryıar		artment of F tificate of L		Mental Hy	/giene Reg. No.	2011	16219
	Physicia	ın/	1. Decedent's Name (,					2. Date of Do	eath Day	Year	3. Time of Death
	Medi Examir		4a. Facility Name (if no	ot institution, g	ive street and number)			4b. City, Town, or		May		County of Death	9:24 AM
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	ath with a	unera	109 Hens	on Rd	12. Was Decedent	Ever in I I	S. 13. V		060	parifu Ven or No		S.A.	
Maryland 21215-0036	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	þ	1 Never Married 3 Widowed 4		Armed Forces?	?		Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🔀 No		o Rican, etc.)		4. Race - Americ Black, White, of Specify: Bla	etc.
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ylanc	should be filed within 72 n and Mental Hygiene. 7 is marked other than "r raumatic event, the Med	I	Emory Bro	wn					18. Mother's Na	me (First, Middle che Sco		urname)	
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8	permi Depa Impo any ir		Ola Bart of Entantha	hich	N. Will	lias						more,	PA MD 21217
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. Box 68760	or Attending Physician: The law requires that the death certificate be after death. Director: After this certificate has been signed by the attending physici in by the funeral director, page 2 should be detached for use as the bu		IF FEMALE: 23b. Was decedent pre in the past 12 mo 1 Yes 2 N 9 Unknown	nths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Feta	l death 3 🗌	Ectopic pregnancy Other (specify)	y		23	3d. Date of delive	ery Day Year
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State	Please	State of M		d / Depa	artment	t of H	lealth and	Mental Hy	giene	2011		20
		Registrar 1. Decedent's Name (F	irst, Middle, La	st)		Cer	tificate	OIL	peatri	2. Date of Dea	Reg. No	2011	3. Time of De	eath
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Examin		4a. Facility Name (if no					4b. City, T	own, or	Location of Deat	h	4c	. County of Dea	th	_
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Funeral Director		5. Social Security Num 212-40-0 Usual Residence of De	154 1	Sex 7. Aq I □ M 2 🔀 F	75	est birthday) Yrs.	Months	Days	Hours Min.			35 Ma	thplace (State or F untry) ryland	oreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examinar must be notified at once.	by	11. Marital Status1 Never Married3 Widowed 4 D		12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		11	f Yes, specif	fy Cubar	spanic Origin? (Sp n, Mexican, Puert Specify:	o Rican, etc.)		14. Race - Ame Black, Whit	e, etc.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DON Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b, City, Town, or Location of Death 4c. County of Death SILVERSTONE 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min, **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Ves 2 No WITGOME. 10f. Zip Code 10g. Citizen of What Country? Funeral 2090 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: 1951 19 N 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) AUTO Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ 19a. Informant's Name/Relationship (Type, Print) RESA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year Yes 1 Yes 2 L 9 Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann f Death 28b. Time of 28c. Injury at Natural iniury 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29c. License number 29d, Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 139 Piccard

State

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #12 Per FH G915 5/25/2011 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician Louise Ciolek Norma /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Severna Park -IVINA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) Jan. 30, Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** . Year) 1917 1□M 2Å F Months Days Hours Min. 94 004-14-8634 **Director** Canada Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical European 2000. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Md. Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1171 Parrish Place 21012 Funeral IISA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes, Give Year or Dates: 1 Never Married 2 Married 1943-1 ☐ Yes 2 ☒ No Specify: 2 Specify: White 3 Widowed 4 Divorced 1946 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman William Campbell Jeanette Hogbin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Ciolek (Daughter 1171 Parrish Place, Arnold Md. 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Central Cemetery Rye, New Hampshire 4 ☐ Donation 5 ☐ Other (Specify) 5/24/11 22. Name and Address of Facility Stallings Funeral Home PÄ 21. Signature of Funeral Service 3111 Mountain Rd. Pasadena, Md. 21122 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ovarian Cancel lears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Else U.S. rhying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 1 No Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😈 Unknown Completed director, page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate performe 2 🗆 No Division of Vital 1 □Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 211 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Pother (Specify) Certification: To funeral c 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending hours after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

State Registrar

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31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

who completed cause of death (Item 23a)

32. Registrar's Signature

ans Hwy Millgaville

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5 Year 9.45AM Beverly enpo Medical 105 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6820 Wisconsin Avenue #8002 Montgomery Chevy Chase Social Security Number 6. Sex . Age (In yrs. last birthday) 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Months Days Hours Min. (Month, Day, Year) Director New York 107-34-6022 68 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "---- any injury or other than 27 is marked other than "----10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 🔀 No MD Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6820 Wisconsin Avenue #8002 20815 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Widowed 4 X Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Community Activist Non-profit Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Robert Brown Matilda Peary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Denbo/son 3915 Woodbine Street Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 05/20/11 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L Heckrotte, P.A. Clarksville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death Malianant Neoplasm disease or condition Medical resulting in death) Due to (or as a construence of): **Examiner** Sequentially list conditions, Duri to for as a nonsequence of, Exami cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Dav Year 1 Yes 2 signed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performe certificate Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Piccard eman 32. Registrar State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Dennis W. Dishman M 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 59401e 5. Social Security Number ta ROSedale If Under 1 Year | If Under 24 Hrs. HOS more Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) June25,1971 7. Age (In yrs. last birthday) **Funeral** Days Months XIM 2 F Director 39 UNKNOWL Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore MD Rosedale 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1818 Wilhelm Avenue 21237 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ XGo Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Roofer Construction 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evone. Jackson Dishman Elizabeth Ann Spiker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita Arnoldt /sister 2519 Running Wolf Trail Odenton MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State TempleHillMemorial 5/21/11 Castlewood VA 4 ☐ Ronation 5 ☐ Other (Specify) 21. Sig atule of Funeral Service Licensee 22. Name and Address of Facility 2. Name and Address of Facility 300 MAce Ave. Balto, MD Connelly Funeral Home of Essex 21221 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** omplications of End Stage Renal disease or condition /Medical resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or): Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 □ No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1√Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide

Examiner attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760 as) ed by the a detached f signed by t has this certifical

ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at

nd Mental Hygiene. marked other than "natural",

ould be f

filed within 72 hours after death with

Maryland 21215-0036

Baltimore,

Hospital or Attending Physician; 1 24 hours after death.

Pe Funeral Director: 4
pletely filled in by the fi within 2

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MD D0069296

Drive Baltimore MD 21237

State

Medical

31. Date filed (Month, Day, Year)

NAY 2 0 2011

Registrar

3

9000 Franklin Square

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ganglam

MAY 17, 2011 10:33 p.m. Raltimore Maryland 21215-0036 DORIS DIFFENDAL

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		Physicia Medic		Doris	ne (First, Middle, La P. Diffen	dal						2, Date of D Month May		Day Year 2011	3. Time of Death 10:33 P ^M
1		Examin	ier	4a. Facility Name (e street and number)			1	, Town, or Locatio	n of Death		4	c. County of Deat	
		Funeral Director	Г	5. Social Security N 213-32-4	4234 6. S	ex 7. Ag	e (In yrs. i 92	last birthday) Yrs.		r 1 Year If Und		8. Date of B (Month, D Aug.]	irth Day, Year)		tholace (State or Foreign
		yland •f show ed at	įģ	Usual Residence o 10a. State	f Decedent 10b. County		10c. Cit	ty, Town or Lo	ocation						10d. Inside City Limits
		ne Mar or 28a notifi	Director	MD 10e. Street and Nu	Baltimo mber	re	Ba1	<u>timore</u>		p Code	_		10.		1 Yes 2 X No
		with the s 23a c ust be	Funeral		sby Road					21228			10g. (Citizen of What Co USA	ountry?
р.ш.	920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	5	11. Marital Status	ried 2 Married	12. Was Decedent to Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.			Was Dece If Yes, spe	dent of Hispanic C cify Cuban, Mexic 2 🛣 No Specia	an, Puerto R	ify Yes or No lican, etc.))-	14. Race - Ame Black, White Specify: Wh:	e, etc.
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17	e, M	and 2 Health em 27		Ronald I	Diffendal nosition	Son	20h E	9811 Place of Dispo		ry Hurst					_
MAY	altimore,	Page 1 nent of int: If ii		1 🔀 Burial 2	'	Removal from State	0	emetery, cre	matory or i			2011	1	Location - City or ridge, M	
-	Balti	permit. I Departra Importa any inju			neral Service Licens		N		_						b Witzke MD 21228
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		Physician/ Medical		Immediate Cause disease or condition resulting in death)	(Final	a. CEREBRO	VASCI	JLAR A							Onset and Death
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S DIFFENDAL		the death certificate be exy y the attending physician ached for use as the burial	Physician/Medical	23b. Was decedent in the past 12 1 Yes 2 9 Unknown	No	23c. If yes, outcome 1 Live Birth 4 Pregnant at 9 Unknown	or pregna 2 Feta t time of c	ncy Il death 3 [Ieath 5 [Ectopic Other (s)	pregnancy pec <i>ify</i>)			53	23d. Date of del Month	ivery Day Year
	ds, P.O.			Part II. Other signif	ficant conditions of	ontributing to death b	ut not res	ulting in the u	underlying	cause given in Par	rt I.				the cause of death?
	\ddot{c}	as as	Completed by									24a. Was auto perf	opsy ormed?	prior to death?	copsy findings available completion of cause of
	ita	nysician: iis certific director,	Be	25. Was case referred examiner?	_ F	Hospital:				26. Place of De		only one)			
	of <	ding Phys th. After this funeral di	e: To	27. Manner of Deatl	X NO	1 Inpatie	v	ER/Outpatier 28b. Time of		DA Other. 4 🗆 N		e 5 Resi			fy) HOSPICE
	ion	tendin leath. or: Aft the fun	Certificate:	1 X Natural 2 Accident 3 Suicide	5 ☐ Pending Investigation 6 ☐ Could not be		, Year)	injury	M	work? 1 ☐ Yes 2 ☐					
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n	, :	Fune e Fune	Medical	(Check 2		sician: To the best of a	kamination	and/or invest	tigation, in	my opinion death of	occurred at the	e time date :	and place	e and due to the o	ause(s) and manner stated
~		To the vithin To the compl	≥	29b. Signature and		e Practioner: To the	best of my	knowledge,	-	med at the time, da License number		and due to th		(s) and manner as a ate signed (Month	
			ļ	M	Josesa	NP				B14970	92		ر ا	5 18/20	11
	_	\sim		30. Name and addre	s of person who c	ompleted cause of de	eath (Item	23a) (Type, F	Print)					*	

State Registrar JACKIE JONES, CRNP 31. Date filed (Mooth, Day, Year) NAY 2 0 2011

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registry's Signafure

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 04:00 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Northwest Hospital Randallstown Social Security Number Funeral . Sex 1 M 2 □ F 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 25, 9. Birthplace (State or Foreign Maryland 1927 Director 214-22-9094 83 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral USA 21214 6613 Knottwood Ct. death 12. Was Decedent Ever in U.S.
Armed Forces?
1 Property 1950-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner 0 1 Never Married 2 Married Completed by and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Black "natural", 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 1ongshoreman boating Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o ပ္ Henrietta Louisa Brown William Alfred Davenport and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6008 Amberwood Rd; Balto, MD 21206 Cheryl Sheffield - sister t of Health of If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 g 20c. Location - City or Town, State 1 \square Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 N Other (Specify) in state injury or Department of Important: If any injury or 22. Name and Address of Facility State Anatomy Soard Ronald 5. Wade Signature A >655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transi Cause (Disease or imjury that Initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 as the t IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Pregnant at time of death Other (specify) 2 No g Unknown g 🗆 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform certificate Yes 2 1 Yes 2 19 No To the Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral direction. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 🔲 Yes 2 🗌 No Accident Investigation 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check and title of c 29c. License number State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr e915 5-20-11 yr State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** May 8, 6:35 AM /Medical Marcia Douglas-Yarborough 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examiner De1mar

Jer 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 1952)

Nay 5, 1952 8773 Sweet Pea Court #104

5. Social Security Number | 6. Sex | 7. Age (Wicomico If Under 1 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 F Mary land 59 218-58-1018 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2X No Director MD Wicomico Delmar 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21875 8773 Sweet Pea Ct; Apt 104 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** 1 ☐Yes 2 No þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) office administrator real estate permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygit Important: If item 27 is marked other any Injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be Aaron Lincoln Douglas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 244 Somers Cove; Crisfield, MD 21817 19a. Informant's Name/Relationship (Type. Print) Felisa Games - sister Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature of Emeral Service Ronal a 655 W. Baltimore St; Balto, MD 21201 Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate C se (Final disease or con infon resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for es a consequence offi Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE: asn. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş page 2 should be 1 ☐ Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an has autopsy performe certificate 2 **X**No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only onle) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 27. Manner of Jeath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2/ Accident 24 hours after deatl Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one) and manner stated. the within To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) uason MD 100 East Carroll St.Salisbury, Md. 21801-5422 ania 31. Date filed (Month, Day, Year) MAY 20

DHMH 17 Rev 1/2001

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item of Maryland Department of Heath and Mental Hygiene

Certificate of Death

		1 - State Registrar			Certific	cate of L	Death		R	eg. No. U		10220	
		1. Decedent's Name (First, Middle,	Last)					2.	Date of Dear	h Day	Year	3. Time of Death	
Physic		Lawrence Eric D	unn Jr					I	April 2			12:30 P	_
/Med Exam		4a. Facility Name (If not institution,	give street and number	-)	4b.	City, Town, or	Location of	Death		4c. Count	ty of Death		
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Funera	al			ge (In yrs. last bir	Mor	Inder 1 Year hths Days	If Under 24 Hours	Min	. Date of Birth (Month, Day	Year)	Con	place (State or Foreign	7
Directo	r	579-06-0588	1 € M 2 □ F	32	Yrs.			1	2 June	19/8	Wash	ington DC	_
pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City. Tow	n or Location	1						10d. Inside City Limits	
aryla shov	,		Georges	Bowie								1 XYes 2 □ No	,
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er de item	ğ	11. Marital Status 1 X Never Married C Marrie	Armed Forces	?	If Yes	, specify Cuba	n, Mexican,	Puerto Ri	fy Yes or No- can, etc.)	BI	ack, White,	etc.	
rs aft	Ş		If Yes, Give Year or Dates		1 □ Y	es 2X No	Specify:			Spec	eify: B1	ack	
be filed within 72 hours after death with the Maryland ntal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Madeal Examiner must be notified at	Pe	15. Decedent's	Education		. Decedent's	Usual Occup	ation			16b. Kind of	Business/I	ndustry	
in 72 in 72 in me	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	.5.1)	(Give kind o life. DO N	of work done of OT use retired	during most (i)	or working		Univer	sity	of the	
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nd 2 alth a 27 is		Lawrence Eric D	unn Sr/Fati	her 1	1224 W	estpor	t Driv	ve, B	lowie,				
s 1 a		20a. Method of Disposition		20b. Place o	of Disposition	(Name of y or other place	ce) (C)5 Ma	te Y	20c. Location	n - City or T	own, State	
Page Pent cent cent cent cent cent cent cent c		1 x Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		e		tional		2011		Laure1	, Mar	y1and	
Datitinoie, Mai yiai permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic ex	형	21. Signature of Funeral Service Li	cepsee	- 6 4	22. Nar	me and Addre	ss of Facility	Robe	ert G l	Mason 1	Funer	al Home In	С
a Tee	-SDICE	MIKCH	DUNDED!	S. CRO	166	1 Good	Hope	Rd S	E, Was	hingto	n DC	20020	
		23a. Part 1. Enter the disease, o c shock or heart failure. List o	o plications that caus	ed the death. Do	not enter the	e mode of dyir	ng, such as o	cardiac or	respiratory ar	rest,	Į.	Approximate Interval Between	
Physicia	n	Immediate Cause (Final	7	BRAL	240	conn	(1/2 m)				1	Onset and Death	
/ /Medica	_	disease or condition resulting in death)	a. Due to (or a	as a consequence	of):	nico	ion						
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	<u>ة</u> إ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	D.	as a consequence									
cuted Id ansit	Examiner	Cause (Disease or injury	. DIAS	ピアごろ	1750	11/10	15						_
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ng P ng P offert inera	ġ	27. Manner of Death 1	28a. Date of I (Month,	njury 28b. <i>Day, Year)</i>	. Time of Injury	28c. Inju Wo			8d. Describe	now injury oci	currea		
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urs at ral D			g Physician: To the be	et of my knowled	ge dooth as	ourred at the f	ime data so	nd place 3	and due to the	cause(s) and	d manner a	s stated.	
Hosp 24 hor Fune tely f	100	29a. Certifier 1 Certifying (Check only 2 Medical E	g Physician: 10 the besi Examiner: On the basi and manner	s of examination a	and/or invest	igation, in my	opinion, dea	ath occurre	ed at the time	date and pla	ce, and du	e to the cause(s)	
DIVISION OT VITAL RECORDS, P.O. BOX 05/00, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Modioal	29b. Signature and title of certifier	and manner	JIGIGU.		29c. Licen	se number			29d. Date si	gned (Mon	th, Day, Year)	_
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		30. Name and address of person v	who completed source	of death (Item 23a) (Type Prin	1)	NOU	7		1/0	20/0		
51		20. Name and address of person of	MIO COMpleted Cause C	USAAN	1 (Type, Fill)	NE	41951	11115	1000	DC	. 0	00/7	
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or Attending Physician: Division of Vital Hospital

28f. Location (Street and Number or Rural Route Number, City or Town, State) 300 Block Burnside St 3 X Suicide 6 Could not be determined (Specify) body of water Homicide Annapolis,Md. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 8, 2011 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State Registrar

Wedical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ Cynthia D. Elder 20ÎÎ 16 6:45 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) lay 2, 1960 1 M 2 Ty F Months Hours 226-21-0268 51 Marvland **Director** May Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits death with the Maryland Director 10c. City, Town or Location or 28a-f sl Silver Spring 1 🗌 Yes 2 🛱 No MD Montgomery 10e Street and Number 10f. Zip Code 5 10g. Citizen of What Country? items 23a or ner must be r Funeral United States 20902 1135 University Blvd. West, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iter idical Examiner Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify. White Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than aumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) (Unknown) (Unknown) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Brewer ည Marshall Barbara Ralph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David W. Marshall / Brother 162 Commodore Lane, Galax, VA 27 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or oth once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 05/19/2011 Beltsville, MD ature of uperal Rapp Funeral and Cremation Services Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ END STAGE HEPATIC FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** ALCOHOL ABUSE Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or linjury Due to for as a nonsequence of as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2XXNo Year Month Pregnant at time of death 9 Unknown 1 ☐ Yes ∠∧ 9 ☐ Unknown To the Hospital or Attending Physician: The law requires that the de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4XX Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsv page ; perform 1 Yes 2 No 1 Yes XX No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2**XX**No 1 🗌 Yes ျ XX Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28a. Date of injury (Month, Day, Year) Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident Investigation Suicide 6 Could not be 3 L Suiciae 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) 24 hours a Funeral I 🏅 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MAY 17, 2011 D69288 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20910 1500 Forest Glen Rd., Silver Spring, YODIT W. NEGUSSE M.D.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Edna E. Fusco 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balti more Rose Franklin Square HOSPIta dal Birthplace (State or Foreign Country)
 MD 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** 1 M 2 XF sept. 8, 1925 Months Hours 85 Director Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at Director Middle River MD Baltimore 1 ☐ Yes 2X No 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 21220 permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b 15 Cockpit Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married Ş If Yes, Give Year or Dates 1 ☐ Yes 2 TNo Specify. Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore, Maryland 2121 College (1-4 or 5+) Elementary/Seconday (0-12) own home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Orash ပ္ John Walters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15 Cockpit Street Baltimore MD Robert Fusco /son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial , 2 X Cremation 3 Removal from State Bayview Crematory 5/16/11 Baltimore MD ation 5 Other (Specify) 22. Name and Address of Facility 21. Signatury of Funeral Service 300 Mace Ave. Balto. MD Home of Essex 21221 Connelly Funeral Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ AC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ending physician and use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Month Dav Year 5 Other (specify) Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Wes 2 □ No 3 □ Probably 4 □ Unknown Renal Completed To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been six completed filled in by the funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 1 ☐ Yes 2 ☑No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Mnpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred 28c. Injury at Certificate: (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 05-12-11 MD 50000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Shikha

31. Date filed (Month, Day, Year)

MAY 20

1025CD

Franklin Squale Drive

9000

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Helen Loeber Freese ^D2011 May 3:54 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Timmonium Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Social Security Number 168-03-9414 '. Age (In yrs. last birthday) **Funeral** 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 ☐ M 2 🛣 F Months Davs Hours 12/28/1917 **Director** PA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Towson 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Dulaney Valley Road 21204 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White If Yes. Give 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unkn. Bryan John Loeber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) $12\ Manitook\ Mtn.\ Road,\ Avon,\ CT\ 06001$ David B. Freese Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey crem. Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/18/2011 Woodbine, MD 21. Signature of Funeral Service Licensee porota Marshall 22. Name and Address of Facility
Maryland Cremation Services PO Bo x1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any 4-auting to immediate Examine Date to for es a consectiones on cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 X No 1 Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) 1 Tyes 2 X No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? Accident Investigation 2 No after deat Suicide 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 3 😿 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) KLS CKN f person who completed cause of death (Item 23a) (Type, Print) JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

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Registrar

31. Date filed (Month, Date

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e,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Ida K. 9 20a. Method of Disp		/ Wife		20b. F	403 Place of Dispo			Avenue.	North Ea		tion - City o		State	\dashv
10 10	age 1 ent of nt: If i		1 ☐ Burial 2 I 4 🛣 Donation		3 Removal fro	m State		emetery, crer tany Gi:	. *		1	9/2011	Hanos	zor N	(artz)	band	
Baltimore,	mit. For partmoortal		21. Signature of Far				IAK					natomy (<u> </u>	┪
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Box 68760	eath certificate b attending physic	Completed by Physician/Medic	IF FEMALE:											10.000			\dashv
9 X	th cer tendii or use	ian/	23b. Was decedent in the past 12 r			e Birth	2 🗀 Feta	aldeath 3 L			у		23	d. Date of de	elivery Day	Year	- 1
Bo	e deat the at hed fo	ysic	1 Yes 2 Dunknown	No	4		time of o	death 5 L	Other (s	pecify)				MOUTH	Day	real	
P.O.	requires that the de been signed by the should be detached	/ Ph	Part II. Other signif	icant condition	s contributing to	death b	ut not res	ulting in the u	ınderlying	cause giv	ven in Part I.	23e. Did to	obacco use	contribute t	o the cau	use of death?	
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וסר	ling P	ate	 Manner of Death Natural 	5 Pending	(Mo	te of injur onth, Day	y ; Year)	28b. Time of injury		28c. Injury work	y at ? Yes 2 □ No	28d. Describe h	ow injury o	ccurred			
Siol	death ctor; y the	Certificate:	2 Accident 3 Suicide	Investiga 6 Could n	ot be	ce of Iniu	rv ~ At ho	ome, farm, str	M eet_facto		Yes 2 □ No	28f. Location (S	Street and N	lumber or Ri	ura/ Rout	e Number.	\dashv
Division	al or A safter Dire d in b	ပြီ	4 Homicide	determir			. (Specify		,	,,		City or Tov				,	J
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1	Certifying	Physician: To the	best of	my know	ledge, death	occured a	t the time	, date and place, a on, death occurred a	nd due to the ca	use(s) and i	manner as s	tated.	and manner etc	ated
	the H in 24 the Fi	Me	only one) 3	Certifying					death occ	urred at th	e time, date and pla		e cause(s) a	nd manner a	s stated.		iteu.
_	5 wit		29b. Signature and	title of certifier	P				29	c. License		, I	29d. Date:	signed (Mon	th, Day, \	(ear)	
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K	D.		30. Name and addre	ess of person w	ho completed ca	use of de	-	1 23a) (Type, I	4 10)~.	Picino	Sun	me	210	711		
1/1	Sta	e	31. Date filed (Monti	n, Day, Year)		- (r's Signa		~ ~	rey	1 101311/0	1 2060	,,,	. ~(<u> </u>		\neg
	Registr		MAY 202	2011	Beer	d.	400	Ked	_								

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

and address of person who completed cause of death (Item 23a) (Type, Print)

00

Westminster

29d. Daje signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Da 2011 Physician/ May 15, 4:40 Ам Green Oriole Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Augsburg Lutheran Home Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. D&Conth. 23 Yes 1927 Maryland 214-22-8294 83 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County at 10a. State 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2X No Maryland Baltimore Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21207 6825 Campfield Road Apt. 1F . Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Junet. If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 2 Black White etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 27 is marked other than "natural", traumatic event, the Medical Exa White 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Secretary Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Hewell ည Martha Moore John Robert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21286 Towson, Maryland 912 Breezewick Road Green Bob 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 ★ Burial 2 Cremation 3 Removal from State 5-19-2011 Overlea Maryland Gds. of Faith Cem. 4 Donation 5 Other (Specify) permit. 21. Signature of Fu real service Li 22. Name and Address of Facility Ruck Towson Funeral Home, 21204 Towson, MĎ 1050 York Road 23a. Part 1. Enter the disease, or comp lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List or one cause on each line Interval Between Onset and Death Immediate Cause (Final Complications of subdural hematoma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death ed by the a Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be determined δ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: April 25, 2011 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 🔣 No. Fall unknown Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Church 28f. Location (Street and Number or Rural Route Number 212 determined 5513 York Road Baltimore, Maryland Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) and title of certifie 29c. License number 2 May 17, 2011 D18667

Registrar
DHMH 17 Rev 7/2009

State

6 Trimble Hill Court

21093

Lutherville, Maryland

Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Sign

Philip Militello,

Date filed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 2, Physician/ Gillen Linda Dawn 2011 5:40 a.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Layhill Center 8. Date of Birth Mar. 14, 1952 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Country California 1 □ M 2 F Months Hours Min Mar. **Director** 59 <u>542-58-6188</u> Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar and Once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 □ No Takoma Park MD Montgomery 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral United States 20912 #101-145 7676 New Hampshire Ave. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1XXNever Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 🗆 Widowed 4 🗆 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Sales / Underwriter Insurance Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gillen မ William LeRoy Nadine Toomey June 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Gillen / Sister 2397 NE Liberty Ave., Gresham, OR 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Chesapeake Crematory

05/09/2011 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Rappan Funeral and Cremation Services M00382 20910 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Severe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last 1000 Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Onknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation after death Director: / Accident by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

within 24 hours a To the Funeral D 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D-0 467624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Afrooz D. O. Bel Pre Rd. 3227 Sultano 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

11-03240	
Danielle Hall	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Danielle Hall	1- For State	State of Maryla		tment of ificate of		d Mental H		201	1 1623
Physician/ Medical Examine		Danjelle	Hall				2. Date of Death Month April 28, 20	g. No. — Vin Day Year	3. Time of Death 0000 hrs
	4a. Facility Name (if not institu		mber)	4	o. City, Town, or Baltimore	Location of Deat	h	4c. County of D	peath ALIA
Funeral Director	5. Social Security Number		7. Age (In yrs. las		If Under 1 Yea		1.		Birthplace (State or preign
any eny	212-82-2059 Usual Residence of Decedent 10a, State 10b, Cour	1 M 2 1/F	10c City T	36 Yrs.	n		Mar.	7, 1975	Country) May land
* .	11. 10.1	NA	, so sugy			Himore		g. Citizen of What	1 Yes 2 No
th the Maryland 23a or 28a-f she notified at once		land Ave				21225		US	5A
Rer death with ", or items 23 er must be no		Married Armed Fo	2 No	If Ye	Decedent of His s, specify Cubar Yes 2 No	n, Mexican, Puerto	Specify Yes or No- o Rican, etc.)	Specify:	merican Indian, Black, tc. Black
15-0036 filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland of other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once of Completed by Funeral Director	15. Decedent's Education (S Elementary/Secondary (0-1	The second second		during mo	st of working life	tion (Give kind of b. DO NOT use re	tired)	16b. Kind of Busine	ess/industry
21215-0036 uld be filed within 72 Mental Hygiene. marked other than e event, the Medical O Be Comple	17. Father's Name (First, Midd Larw Hall	le, Last)		Crific	- Car C	18.Mother's Nam	e (First, Middle, M		7
o sh o sh o	19a. Informant's Name/Relation Atha Spence	nship (Type, Print) 2—matther		5610	Matt	news C	t. Broo.	ber, City or Town, S Klyn Par	-K, Maryland
MOFE Pages 1 tent of H unt: If i	4 Donation 5 Other	ion 3 Removal fro	m State cre	ematory or other	rem. Pe	irk 5	Date 76/11	/	Meryland
	21. Signature of Funeral Serv 23a. Part I. Enter the disease,	Marke	/	35	me and Addres	enckA	ve. Balt	eral Hominore, M	arylard Approximate Interval
Physician /Medical !xaminer	failure. List only one cau Immediate Cause (Final disease or condition resulting in death	se on each line. se a. Exsanguina		uptured He				st, shook, or heart	Between Onset and Death
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cau	b Due to (or as a	consequence of):						
recuted and transit			consequence of):						
di rial	UNPENDED IF FEMALE:	AMENDED 23c. If yes. o	outcome of pregna	ancy				23d. Date of de	livery
box 68760, the death certificate by the attending physic ched for use as the bur Physician/Meo	23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 ✓	the 1 Live bi	rth ant at time of deat	2 Feta	al death 3 er (Specify)	Ectopic pregn	ancy	Month	Day Year
T leaf the Leaf	right ankle fracture		death but not res	ulting in the ur	derlying cause	given in Part I.		bacco use contribut	te to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the start cleath. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deadd estable retification: To Be Completed by F							24a Was a autops perform	sy prio med? dea	re autopsy findings available r to completion of cause of th? Yes 2 No
Vital Reco		tte e sitete		700 1-11		of Death (Check		Residence 6	
on of Virending Physicath. ath. After this he funeral dir tion: To		28a. Date (Month) Apr 28, 2	of Injury 2	R/Outpatient 28b. Time of In 1225 hrs	ury 28c. Inju	ury at Work? Yes 2 ✓ No	28d. Describe h	ow injury occurred playing volley	
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune edical Certification:	2 Accident In 3 Suicide 6 C 4 Homicide	ould not be	of Injury - At hon Beach area	ne, farm, street	, factory, office I	building, etc.	28f. Location (S or Town, Si , Ocean City, N	tate)	or Rural Route Number, City
To the Bospital within 24 hours To the Funeral completely fille		Physician: To the best xaminer:On the basis of and manner st	f examination and						
E P S P S	29b. Signature and title of cer		ก		29c. Licens O.C.			29d. Date signed April 29, 201	(Month, Day, Year)
\O	30 Name and address of personal Pamela E. Southall		e of death (Item 2 Medical Exam		W. Baltimor	re Street, Balt	imore, MD 21	223	
State Registra	10 1 1/2 1/2 1/2	0 2011 2	gistrar's Signature	bay	Les .				
DHMH 17 Rev 1/2001				ORIGINAL			OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 7 per 1h g915 5-23-11 vt. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2 0 1 1 Month Physician/ 7:20 PM Pauline S. Hough 18 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 3046 Arizona Avenue Parkville 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Month, Day, Y. Hours 1 M 2 X 1920 West Virginia 236-22-5265 90 Yrs. Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho, amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County Director 1 ☐ Yes 2 X No MD Baltimore Parkville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 3046 Arizona Avenue 21234 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11 Marital Status Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) At Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rose Shriver George Bowers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4500 Dunton Terrace Apt. R-Perry Hall, Maryland 21128 Phillip Hough-son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Martinsburg, West Virginia Pleasant View Cemetery May 24,2011 Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ALZUKIMER; D1 > EA-18 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trar that initiated events signed by the attending physician and Due to (or as a consequence of) resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav 5 Other (specify) 1 ☐ Yes 2 № 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? STENSSIS 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 000 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 24 hours after death. Funeral Director: A Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the f only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific 26637 m) who completed cause of death (Item 23a) (Type, Print) Josephs-7600 Osler Drive Suite 311-Towson, Maryland 21204 32. Registrar's Signature State back Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of N - State Amend Item23a per	Maryland Dep Ce Ce	actment 26 H ertificate of D	ealth and Me dhb e <i>ath</i>	ental Hygien Reg. N	2011	16239
F	Physicia	n/	1. Decedent's Name (First, Middle, Last)			2	2. Date of Death Month	Day Q 2Year	3. Time of Death
	Medic Examin	al	John Wesley Hooks 4a, Facility Name (if not institution, give street and number) .	4b. City. Town, or L	ocation of Death	1 1	c. County of Death	10 - 33 A-M
	Lamin	CI	St. Joseph Medical Ce	nter	TOWSOV	1		Baltin	ore
	Funeral Director		5. Social Security Mumber 070-26-6558 6. Sex 1 ☑ M 2 ☐ F	Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	Hours Min. A	B. Date of Birth (Month, Day, 2937, UGUST 23	9. Birthp	place (State or Foreign Pork
Т	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			1	0d. Inside City Limits
	Maryla 28a-f s etified	Director	Maryland Baltimore	Baltimor	e				1 🗆 Yes 2 🔀 No
	h the /	al Di	10e. Street and Number		10f. Zip Code		1	Citizen of What Cour	try?
	ath wit ms 23 must	Funeral	1020 Marleigh Circle 11. Marital Status 12. Was Deceder	t Ever in U.S. 13	21204 Was Decedent of His	panic Origin? (Specif		S.A.	an Indian
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mentall Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 X Married 3 Widowed 4 Divorced 12. Was Decedent 12. Was Decedent 13. Yes 2 If Yes, Give Year or Dates	s? □ No	If Yes, specify Cuban 1 Yes 2 X No	, Mexican, Puerto Ric		Black, White, Specify: Whit	etc.
5-0	72 hou "natu ledica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupate kind of work done du	tion Iring most of working	16b.	Kind of Business Inc	dustry
212	within jiene.		Elementary/Seconday (0-12) College (1-4 c	r5+) [DO NOT use retired) itor		Ir	nsurance	
Baltimore, Maryland	ntal Hyg ed other event,	To Be	17. Father's Name (First, Middle, Last) John Wesley Hooks, Sr.			18. Mother's Name (F		•	
aryli	should be file and Mental } 7 is marked o raumatic eve	·	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ling Address (Street ar				
Σ	ge 1 and 2 si it of Health a it item 27 i or other tra		Martha G. Hooks / Wife		Marleigh				
nore	age 1 a int of H t: If ite / or oti		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta		ematory or other place			Location - City or To nonium, Ma	
alti.	mit. Pa bartme bortan r injun		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Sovice Licensee		Valley Men 22. Name and Address				
Ä	Departition Depart		Muleyanan	$ \mathcal{U} _1$.050 York F	Road Towso	n, Maryla		
	nysician/ Medical		23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)	static Re	nal Cell	Λ	DOMO.		Approximate Interval Between Onset and Death
	Examiner		Due to (or a	as a consequence of):	steess	with Pas	orline. A	rrest	
^	n ##	niner	cause. Enter Underlying	as a consequence of):		<u> </u>			
17.	xecuter and	Examiner	that initiated events	as a consequence of):					
90	e be e iysiciar ne buri	edical	d						
3876	ertificat ding ph	/Mec	IF FEMALE: 23c. If yes, outcor	ne of pregnancy					-
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	h 2 Fetal death 3 t at time of death 5	Cother (specify)			23d. Date of deliv Month	Day Year
Division of Vital Records, P.O.	quires that t en signed b uld be deta	by	Part II. Other significant conditions contributing to deat	n but not resulting in the	underlying cause give	en in Part I.		o use contribute to the	ne cause of death?
Secon	he law rec ite has bee vage 2 sho	Completed					24a. Was an autopsy performed 1 Yes 2	prior to co	psy findings available mpletion of cause of
ta	Physician: The lav r this certificate has aral director, page 2	Be	25. Was case referred to medical examiner?		lo:	ce of Death (Check o			
Ž	Physi rthis c eral dire	e: 10	1 ☐ Yes 2 ☐ NO 1 ☐ Inp 27. Manner of Death 28a. Date of i	atient 2 ER/Outpatie		4 L Nursing Home	e 5 Residence d. Describe how inj	6 Other (Specify)
ouo	arth. rr. Afte	icate	1 Natural 5 ☐ Pending (Month, I	Day, Year) injury	work?		a. 200020	any cocamor	
ivisi	al or Atters after de I Directo	Certificate:		Injury - At home, farm, st etc. <i>(Specify)</i>	treet, factory, office	28	Bf. Location (Street a City or Town, Sta	and Number or Rura te)	Route Number,
	ne Hospite n 24 hours ne Funeral pieted fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of 3 Certifying Nurse Practioner: To the basis of the control of the basis of t	of examination and/or inve	estigation, in my opinior	n, death occurred at th	e time, date and pla	ce, and due to the ca	use(s) and manner stated.
	To the Complex		29b. Signature and title of certifier		29c. License	number	29d. [Date signed (Month,	
	M		30. Name and address of person who completed cause of	f death (Item 23a) (Type	Print) H 3	8408		ay 14,	2011
	100,		Neal Frankel D.O. 76	01 Osler	Drive	Towson	, MD 2	1204	
	Stat Registra		31. Date filed (Month, Day, Year) NAY 2 0 2011	strar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Harrison 5:00 A Physician/ Velma. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Place Baltimore Entaw 9. Birthplace (State or Foreign Country) Mary GNA | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, last birthday **Funeral** 1 🗆 M 2 🗹 F 76 213-30-338 Yrs **Director** Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". or item marked other than "natural". 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director Battimore 1 Yes 2 No Maryland 10f, Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 21217 1617 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. b 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☑ No Specify If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Private Elementary/Seconday (0-12) College (1-4 or 5+) Worker Socia Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Helen Gaines campbel Edward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bowie, Marylan daughter Clearfield rlean 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 19 Woodlawn 4 Donation 5 Other (Specify) Euneral Home, F.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Interval Between shock, or heart failure. List only one cause on each line Onset and Deal Immediate Cause (Final Ph, i ian/ ononthe neuroendocrine disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and a be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 4 ☐ Pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 - Natural injury 5 Pending 2 🗌 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Territying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifies

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signature

coni

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) P^{M} May 2011 5:00 Jeffrey Hazard 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Broadmead Retirement Community Cockeysville Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 New York 8. Date of Birth (Month, Day, Yo April 1, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year Days Hours Months 1**X** M 2□ F 1916 036-12-8098 95 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1X Yes 2 □ No MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21210 USA 6 Over Ridge Ct; Apt 3922 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Kilyes 2 □ No 1941—
If Yes, Give
Year or Dates: 1946 Black, White, etc. 1 Never Married 2 Married Specify: White 1 □Yes 2X No 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) sales autoparts 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Isaac Peace Hazard Katherine Burnet 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William Hazard - son 16 Shoreham Ct; East Windsor, New Jersey 08520 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4X Donation 5 □ Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) 2 month disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner

Department of Important: If it any injury or c once.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

items 23a or 28a-f shov

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and 2 should be filed within 72 hours after of teath and Mental Hygiene.

item 27 is marked other than "natur other traumatic event, I'm Medical

of Health

Baltimore, Maryland 21215-0036

5:00 pm

HAZAR

reffacy

Director

Funeral

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Completed

Be

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physician and s the burial-trans attending pl signed by the a certificate has been si rector, page 2 should director, funeral After

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner Be Completed by 25. Was case referred to Certification: To 27. Manner of Death

And the second s	Sequentially list conditions, if any, leading to immediate cause. Liner Uniterning Cause (Disease or injury that initiated events resulting in death) Last
	IF FEMALE: 23b. Was decedent pregnant

examiner?

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

1 □ Yes

in the past 12 months? 1 □Yes 2 □No

2 1 No

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death Pregnant at time of death 9 I Inknown

28a. Date of Injury

and manner stated

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

3 Ectopic pregnancy 5 Other (specify)

ath but not resulting in the underlying cause given in Part I.

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 2 🗷 No 1 Tes

24a. Was an performed 1 ☐ Yes 2 **/** No 26. Place of Death (Check only one,

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 2 No

5 ☐ Pending investigation	(Month, Day, Year)	injury M	work? 1 ☐ Yes	2 🗆 No	
6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office		28f. Location (Street and Number or Rural Route Number City or Town, State)
1 Certifying Physic	clan: To the best of my kno er: On the basis of examina	wledge, death occurre	ed at the time, on, in my opinion	late and place	I e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)

13801

28c. Injury at

9b. Sign	ature and title of certifier	0	1120
	Railland	111	11/1/M
	MAMMINA		nauci 12V

29c. License number D38392

YORK

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

State Registrar

Medical

within 24 hours after death

To the Funeral Director:

completely filled in by the 1

State Registrar

Jones

DHMH 17 Rev 1/2001

Dr. Sevastian
31. Date filed (Month, Day, Year)

7

9000 Franklin

Begistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Square prive Baltimore, MD 21237

			State of Maryland / Dep	artment of Health and Me		
			1 - State Registrar Ce	rtificate of Death		2011 16243
	Physicia Medic		1. Decedent's Name (First, Middle, Last) CATHERINE MARIE KELLY		May 19,	3. Time of Death 8:55 A M
	Examin	er	4a. Facility Name (if not institution, give street and number) STELLA MARIS HOSPICE	4b. City, Town, or Location of Death Timonium		4c. County of Death Baltimore County
ł	Funeral Director		5. Social Security Number 6. Sex 1 \square M 2 $\overline{\mathbb{X}}$ F 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth $Nov^{(Month,Day,}$ 1	9. Birthplace (State or Foreign County) Mary Land
	and show at	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Low	ocation		10d. Inside City Limits
	Maryla 28a-f	irect	Maryland Baltimore County Balti	more		1 ☐ Yes 2 💢 No
	with the	Funeral Director	10e. Street and Number 222 Rodgers Forge Road, Apt A	10f. Zip Code 21212	100	g. Citizen of What Country? USA
	r death r items iner mu	/ Fun	Armed Forces?	! Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.
9003	urs after tural", o al Exam	ted by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🕅 No Specify:		Specify: White
215-(72 hor an "nat Medica	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working O NOT use retired)	, 16	Sb. Kind of Business Industry
121	d withii lygiene ther th: tt, the	Be Co	Z Assis	tant Vice President		Banking
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To B	17. Father's Name (First, Middle, Last) Jerome Gregory Kelly, Sr.	18. Mother's Name (Barbar		den Surname) Maulden
Mar	d 2 shou alth and 1 27 is m er traum			ng Address (Street and Number or Rural F [urdock Road, Baltin		•
ore,	ge 1 an nt of He : If item or othe		Table Bullar 2 - Ordination 5 - Helitoval Holli Otate	matory or other place)		Cc. Location - City or Town, State
altim	mit. Pag bartmer sortant rinjury 26.	- 3		's Ch Cem. 5/23/2		altimore, Maryland
Ä	permi Depar Impor any ir	j	Martin D. Lawson	MTCHELL WIEDEFELD 6500 York Road, Bal	ltimore,	Maryland 21212
Į,	Pnysician/	§ 10	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition END STACE RENAL.		respiratory arrest,	Approximate Interval Between Onset and Death
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		iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of);			
	be executed sician and burial-transit	Examiner	Cause (Disease or linjury that initiated events c			
90	te be ey nysiciar he burīa	g	d			
687	eath certificate k a attending phys d for use as the b	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	_		23d. Date of delivery
. Box 6876	the Hospital or Attending Physician: The law requires that the death certificate thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physmpleted filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	in the past 12 months? 1 Live Birth 2 Li Fetal death 3 i	Ectopic pregnancy Other (specify)		Month Day Year
Division of Vital Records, P.O.	requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death?
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Vital	ysician s certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (Check of Death) Other:		te 6 X Other (Specify) HOSPICE
Jo u	ding Phy th. After thi funeral		27. Manner of Death 1	f 28c. Injury at 28 work?	d. Describe how	
visio	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, stream building, etc. (Specify)	M 1 Yes 2 No reet, factory, office 28	Bf. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
Ö	spital or hours a neral D	Medical C	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, and	due to the cause(s) and manner as stated.
	the Hothin 24 the Fu	Med	(Check 2 Medical Examiner: On the basis of examination and/or investing only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	death occurred at the time, date and place,	and due to the ca	use(s) and manner as stated.
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		29b. Signature and (title of certifier	D43725	29d	I. Date signed (Month, Day, Year) 5 19 1
	No,		30. Name and address of person who completed cause of death (Item 23a) (Type,		m 0122	
	Stat	e	TARIQ MAHMOOD, MD 2300 DULANEY VALI 31 Cale files (Month Pay Year) 32. Registrar's Signature	EY RD. TIMONIUM, 1	MD 21093	· · · · · · · · · · · · · · · · · · ·
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	Funeral		5. Social Security N			ge (In yrs. Ia	st birthday)	If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. Min,	8. Date of Bi (Month, D	rth av. Year)		9. Birth	place (Sta	ate or Foreign
	Director		216-66-9	536	1 □ M 2 🛣 F	53	Yrs.	Monard	Duyo	T T G G T G	,,,,,,,	11/24	+/19	57		RÝLAN	JD
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e Ma			MD	ID N/A			BALTIMORE CITY								1 🚅	Yes 2 □ No	
÷			10e. Street and Number				10f. Zip-Code						10g. C	itizen of \	What Cour	ntry?	
h wit			3139 E. BALTIMORE STREET APT.			APT.	В 21224					USA					
deat			11 Marital Status 12. Was Deceder			Ever in U.S. 13.		Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e			cify Yes or No)-	14. Rac	e - Americ		٦,	
iffer on	or ite		1 🛚 Never Marri	ied 2 Married	Armed Forces		- 1				Pueno	fican, etc.)			ck, White,		
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D	Health and Mental em 27 Is marked o ther traumatic eve	0	17. Father's Name (First, Middle, Last)				1			18. Mother's Name (First, Middle, M			e, Maide	, Maiden Surname)			
g pg		To B	BLAINE F. KIRKSEY				STEP			STEP	PHANIE T. BUTCHECK						
Maryland d 2 should be file		-	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)														
M Z			SYDNEY F	1236 CALDWELL COURT NORTH BELCAMP, MD 21017 Place of Disposition (Name of lemetery, crematory or other place) Date 20c. Location - City or Town, State													
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Baltimore, permit. Pages 1 au	Department Important: I any Injury o once.		21. Signature of ru	Helal Service Lice	i / //	01139					1111	E JOHNS				,	P.A.
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			shock, or hear	ne disease, or con rt failure. List only	np ations that cause e cause on each	ed the death line.	. Do not en	er the mode	or ayın	g, such as	cardiac (or respiratory	arrest,			Interval	timate I Between and Death
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of Vita	s cer direc	examiner? Output Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing						rsing Hor	Home 5 ☐ Residence 6 ☐ Other (Specify)								
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To the Hospital or Attending Physical 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral d Division o

27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury М 1 🗌 Yes 2 🗌 No 3 🗌 Sulcide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

olle

4940 Eastern Avenue, Baltimore, MD, 21224

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

5

Certification

Medical

29a. Certifier (check only one)

Alves 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May^{Month} 14,20I1Physician/ 5:35P Pearl J. Koluch Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto. Timonium Stella Maris If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 6. Sex 8. Date of Birth **Funeral** 1 □ M 2 **X**) F Months 9-10-1929 Mary land Director 81 217-24-5103 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location at Director 1 🗆 Yes 2 No Examiner must be notified Bel Air Md. Harford 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ö 23a Funeral USA 21014 300 W. Ring Factory Road Brightview er than "natural", or items the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc þ 1 Never Married 2 Married White Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates 3 😾 Widowed 4 🗆 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 2 should be filed within 72 th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frances Novak Henry Sobus 2011 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Conowingo, Md. 21908 47 Highview Road Son Edward C. Koluch 14, Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) injury or 5-19-2011 Parkville, Md. 4 Donation 5 Other (Specify) Parkwood Schimunek Funeral Home 22. Name and Address of Facility 21. Signatur 9705 Belair Road Nottingham, Md. 21236 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year ate has been signed by the atte page 2 should be detached for Month 5 Other (specify) Pregnant at time of death Unknown PEARL KOLUCH 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown or Attending Physician: The law requires 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 - No 1 🗌 Yes this certificate Yes 2 X No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) **HOSPICE** Hospital 2 🗶 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 5 Pending injury 1 X Natural Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Check 3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 2011

State Registrar 30. Name and add

JACKIE

JONES,

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

ss of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ May 2011 2:55P M K1onin Arnold Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Harmony Hall Co1umbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In yrs. last birthday **Funeral** Days Hours Min (Manth, Pay, Year) 21 New York 1 X M 2 - F 89 Director 067-14-2757 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location at 10a. State with the Maryland Director Examiner must be notified 1 🗌 Yes 2 🕱 No Columbia MD Howard 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or U.S.A. Funeral 21044 6336 Cedar Lane permit, Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married y Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. White 3 Nidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Air Conditioning Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic & Heating Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Pearl Klonin Emmanuel Klonin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5465 Gloucester Road Columbia, MD 21044 (Daughter) Ellen King 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Garrison Forest Veterans Cemetery 1 X Burial 2 Cremation 3 Removal from State Owings Mills, MD 4 Donation 5 Other (Specify) 5-18-2011 Signature of Funeral Service licens 22. Name and Address of Facility Witzke Funeral Homes, Inc 21045 5555 Twin Knolls Road Columbia, MD Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sign tially interest lines if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burlal-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 1 Yes 2 No been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has death? 1 ☐ Yes 2 ☐ No Yes 2 5 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ြုင 4 Nursing Home 5 Residence To the Hospital or Attending Physi within 24 hours are death.

To the Funeral Director: After this of completed filled in by the funeral director. this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) 5 Pending Accider
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License numbe 30. Name and address of person who co State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh 9915 5-20-11 vt State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lewis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea Examiner Baltima Memorial If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 1933 Birthplace (State or Foreign Country) Funeral Days Min. 220-30-2089 1 □ M 2 X F Director Usual Residence of Deceden 28a-f shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Yes 2 No 10f. Zip Code 10g. Citizen of What Country 5 10e. Street and Number 239 Funeral 1218 OCK items death \ 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 2 No 1 🗌 Yes Specify. laci Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Hime (are Domes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOCK Raven Belmola Lewis 20b. Place of Disposition (Name of cemetery, crematory or other place)

MOST HOLY REJECTION MAY 21,2011 20a. Method of Disposition 20c. Location - City or Town, State 1

■ Burial 2

□ Cremation 3

□ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FREBHITTEN md 2/22 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to humocrate cause. Enter Underlying Cause (Disease or linjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 🗌 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Castily in Nursa Fractioner: To the best of ry nowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Castily in Nursa Fractioner: To the best of ry nowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of cer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) istrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May Physician/ 20°1 8:45 p M 189 LaBarbera Gail Charlene Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Mount Airy Kline Hospice House 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 DM 2 X Months May 3, 1939 215-38-3911 72 PA Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Examiner must be notified at Director Frederick 1 Yes 2 No Frederick MD 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 6 Funeral 23a 21702 U.S.A. 7444 Sundays Lane items; 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married 2 X No "natural", or 1 Yes : Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Margaret Wood Jon Peck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 9301 White Rock Ave Frederick, MD 21702 Anthony LaBarbera / Son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Final Journey Crematory 5/21/2011 Woodbine, MD 4 Donation 5 Other (Specify) Maryland Cremation Services 21. Signature of Euneral Service Licensee Dorota Marshal] 22. Name and Address of Facility any Baltimore, MD 21203 Box 1413 P.O. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or linjury that initiated events ng physician and as the burial-trans To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown is been signed by the should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 4 Nursing Home 5 Residence 6 K Other (Specify) Hospice ျ 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print) Eskander 31. Date filed (Month, Day, Year) 32. Registra s Signa State 20 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Maude M. Metz 8:05 AM 18, May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, Year) Aug. 20, 1925 **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Min 1 M 2 XF 165-22-0658 Pennsylvania Director 85 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD Baltimore Essex 1 Yes 2 Xio 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1050 Middleborough Road 21221 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after white 1 Yes 2 No Specify. "natural", Completed 3 Widowed 4 Divorced Specify: Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmetra. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker At Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clarence Turney Mae Jeffrevs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley Metz-spouse 1050 Middleborough Road-Essex, Maryland 21221 20b. Place of Disposition (Name of cemeter), crematory or other place)
Holly Hill Memorial
Gardens 20a. Method of Disposition 20c. Location - City or Town, State Date Burlal 2 Cremation 3 Removal from State May 20,2011 Middle River, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 indra 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ heart fuilwy Concestive disease or condition resulting in death) we elec Medical Due to (as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Dav Year ned by the a detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by intection Chromic Kidney Records, 2 ₩No 3 ☐ Probably 4 ☐ Unknown 1 Tyes peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed' death? this certificate 2 🗌 No 1 🗌 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 1 No ည 4 Nursing Home 5 Residence 6 other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Part & 7 Wa N 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 2U

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mc Mullen Mav 2011 10:50ah Medical 4a. Facility Name (if bot institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6802 Harewood Park Drive Middle River Baltimore 5. Social Security Number Age (In yrs. last birthday) 73 Yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 8. Date of Birth **Funeral** Days 1 M 2 STF Months Hours A Worth, Pas Year 937 34-997 Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10h County traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore Middle River 1 Yes 2X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6802 Harewood Park Drive 21220 USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 X Married δ 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo White 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Clerk 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mee College (1-4 or 5+) Elementary/Seconday (0-12) Grocery 7th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Louis H. McMullen Alice A. Dashkovich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn McMullen /wife 6802 Harewood Park Drive Balto. MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Holly Hill Cemetery 5/18/11 1 XBurial 2 Cremation 3 Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Atherosclero Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner phera Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last attending physiciar Physician/Medical Box 68760 as the l IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Pregnant at time of death 5 Other (specify) Day Year the P.O. þ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed certificate 1 ☐ Yes 2 ☐ No **Division of Vital** or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending iours after death.

neral Director: Af
ifiled in by the fu 1 🗌 Yes 2 🗆 No Investigation Accident 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours at To the Funeral D completed filled in Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
NAY 2 0 2011 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201°1 Terry B. Mollohan May 18^{Day} 8:10 A Medical 4a. Facility Name (if not institution, give street and number)
8009 Bank Street **Examiner** 4b. City, Town, or Location of Death Baltimore 4c. County of Death 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 - F Months Davs Hours Min. 67 214-44-5300 Director 194 WVA Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8009 Bank Street 21224 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Force Black White etc. þ 1 Never Married 2 married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Mo Specify: If Yes Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry rgiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8th Assembly Line CM and Mental Hygier is marked other permit. Page 1 and 2 should be filed wil Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ova Mollohan Mable Pritt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie Mollohan /wife 8009 Bank Street Baltimore MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State oak Lawn 1 Burial 2 Cremation 3 Removal from State Cemetery 5/23/11 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Signature of Fineral Service Licensee Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, oncomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 N s after death.

Director: After this certificate 2 No 1 Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tyes 2 No 2 Accident Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed car 3a) (Type, Print) 31. Date filed (Month, Day, Year) State MAY 20

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ita Mudd	State of Maryland 1-For State Registrar	/ Department of Certificate of	f Health and Mental H f Death		2011	16252					
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)	2. Date of Death Month May 15, 20	Day Year	3. Time of Death 0923 hrs							
and	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death										
Funeral	Johns Hopkins Bayview Medical Center 5. Social Security Number 6. Sex 7. Ag	ge (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24Hr	s. 8. Date of Birth	n(MM/DD/YYYY) 9. Birth	place (State or					
Director	213-88-7301 _{1 M 2}	48 _{Yrs}	Months Days Hours Mir		Foreign	ntry)Maryland					
any	Usual Residence of Decedent 10a, State 10b. County	10c. City, Town or Locat	ion			10d. Inside City Limits					
	Maryland Baltimore		1 Yes 2								
the Maryland or 28s-fsh iffied at one Director	10e. Street and Number 2116 Merritt Boulevard	10f. Zip Code 21222		g. Citizen of What Count	ry?						
auth with the Maryland items 23s or 28s-f shu ust be notified at once.	11. Marital Status 12. Was Deceden		I as Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - America	an Indian, Black,					
er death v , or item r must bo	1 Never Married 2 X Married Armed Forces 1 Yes 2 3 Widowed 4 Divorced If Yes, Give Yeer	. X №	es, specify Cuban, Mexican, Puerto Yes 2^{X} No specify:	Rican, etc.)	White, etc.	L _					
ours aft	15. Decedent's Education (Specify only highest grade cor	mpleted) 16a. Deceder	it's Usual Occupation (Give kind of	work done	Specify: Whi						
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland cert of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-fahar ruther traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4 or	5+) Super	ost of working life. DO NOT use ret /isor	ired)	State of M	aryland					
ID 21215-0036 should be filed within 7 and Mental Hygene. The marked other than natic event, the Medica To Be Comple	17. Father's Name (First, Middle, Last)			(First, Middle, Ma							
21214 ould be fill d Mental F s marked fic event, I	Robert Frank Emala 19a. Informant's Name/Relationship (Type, Print)	reta Campbell Rural Route Number, City or Town, State, Zip Code)									
ore, MD 2 ss 1 and 2 shou of Health and N if item 27 is n her traumatic	Bradley Mudd (Son) 20a, Method of Disposition		University Drive								
TOTE, ages lant of He t: If ite	1 E Burial 2 Cremation 3 Removal from St	crematory or oth			20c. Location - City or T Baltimore,						
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum.	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee				•	-					
	23a. Part Fotor the disease, or complications that caused	1 the death. Do not enter the	lame and Address of Facility Bruzdzinsk 107 Old Eastern	Avenue, I	Essex, Mary	land 21221 Approximate Interval					
Physician // // // // // // // // // // // // //	fulure. List only one cause on each line.	e Intoxicati		or respiratory arres	st, shock, of fleart	Between Onset and Death					
Examiner	or condition resulting in death) Due to (or as a cons		. OII								
mlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	equence of):									
_ K	College or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
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Box 6876(e death certificate the attending phy ed for use as the b hysician/Me	past 12 months?	ancy	Month Da	y Year							
J. Bo the deat by the at ached for Phys	1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to deat	h but not resulting in the u	inderlying cause given in Part I.	23e Did tob	acco use contribute to th	e cause of death?					
ries that to signed by be detac			and anything course give in any art is		2 No 3 Proba						
Records, The law require ficate has been sig, page 2 should bb				24a. Was an autopsy	prior to co	psy findings available mpletion of cause of					
tal Rec certificate h ector, page 2				perform Yes 2		2 No					
of Vital ng Physician: After this certi meral director	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatie	ent 2 🗹 ER/Outpatient	26.Place of Death (Check 3 DOA Other Nursin		esidence 6 Other:						
n of ding Ph	27. Manner of Death 28a. Date of Inju (Month, Day, Y	28b. Time of li 7ear)	4 - 0 V 0 V		w injury occurred	-					
Division tal or Attendin ts after death. al Director: A ted in by the fu	2 Accident Investigation 28e Place of In	Unknown 28f. Location (Street and Number or Rural Route Number, City									
Division o spital or Attending rours after death. neral Director: Aft filled in by the fune Certification:	4 Homicide determined (Specify) Residence Dundalk, Md.										
in the place of th	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
To with the con	29b. Signature and title of certifier		29c. License number		n, Day, Year)						
	O.C.M.E. May										
	 Name and address of person who completed cause of or Melissa Brassell, MD Assistant Medical 	, ,	. Baltimore Street, Baltimo	re, MD 21223	}						
State Registrar	6 4 6644	ar's Signature	are								

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AMEND ITEM#30perDVR, G915, 5/20/2011 WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MAY 2011 1:30 A M MARILYN PHYLLIS MERWITZ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3005 SOUTH LEISURE WORLD BLVD., #508 MONTGOMERY SILVER SPRING 9. Birthplace (State or Foreign Country), MD 5. Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Days Months Hours Min 272571930 81 Yrs. Director 216-24-6403 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD MONTGOMERY SILVER SPRING 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3005 SOUTH LEISURE WORLD BLVD., 20906 USA #508 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 ☐ Divorced WHITE Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 12 **SECRETARY** INSURANCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည DOROTHY MAX ROSENSTEIN KATZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1414 22ND ST., NW, #42, WASHINGTON, DC 20037 SHERRIE SUSHNER/DAUGHTER or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 Ϫ Burial 2 ☐ Cremation 3 ☐ Removal from State MIKRO KODESH 4 ☐ Donation 5 ☐ Other (Specify) 05/19/2011 BALTIMORE, MD BETH ISRAEL 22. Name and Address of Facility SOL LEVINSON & BROS., Signature of Funeral Service Licensee MD 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death OYR Immediate Cause (Final disease or condition Physician/ ATHEROSCLEROTIC VASCULAR DISEASE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): the attending physician and thed for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ cate has been signed by the atte page 2 should be detached for in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ NARCOLEPSY 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 X No after death.

Director: After this certificate 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🛚 No Other: ပ 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ပ D0003792 5/17/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10301 Georgia Avenue Irnest Oser Silver spring, MD 20902 Reth 32. R State strar's Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 4:00P M 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** <u>Barbara J. Martin</u> May 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gaithersburg Montgomery Wilson Health Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Months Days Director Dec 13, 1941 Washington DC 578-48-2709 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Maxical Examination to Examinate the said of the control of the said of the control of the said of the s 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD 1 ☐Yes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? s 1 and 2 should be filed within 72 hours after death with of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 11409 Ashley Drive 20852 USA Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2 No Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) office manager doctor's office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leman Hine Nevitt Mabel Hall Goodwin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1122 Village Gate Dr; Mt. Airy, MD 21771 19a. Informant's Name/Relationship (Type. Print) Joanne P. Doyle - duaghter 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 ment of H Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funer Long Long Party Property P 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arture to Thrive Adult One month **Physician** /Medical Due to (or as a contro uence of): Examiner Metastatic squaritiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transi Exami Due to (or as a consequence of) Box 68760, requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d Date of delivery 3 Ectopic pregnancy signed by the atte Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ Radiation neumanitis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 No chemathera 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 2 🖪 No al or Attending Physis after death.
I Director: After this c 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manuar of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral D Hospital 29a. Certifier 1 👱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) WeRshert Suschback ush 04115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), 20 / RUSSELL 4 V EN UE / V. ROBERT BIRSCHBACH, NUD, GAITHELS BURY, NUD 208 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:08AM Marie Poole MA 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BAltimore 00 10 Altimake Cit tospital If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 4, 1930 If Under 1 Year 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 X F Douglass Director 237-40-8881 80 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examinating must be notified at MD Baltimore 1 X Yes 2 No Director 10f. Zip Code 21215 10g. Citizen of What Country? 10e. Street and Number 3509 Copley Road USA Completed by Funeral MARie Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or 1 □Yes 2X No Specify: Black 3 → Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) dorm mom Morgan State University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk Department of Health and Mental HI Important: If Item 27 is marked oth any Injury or other traumatic event Be Nathan Marshall Knows Viola Palmer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth V. Poole - daughter 3509 Copley Rd; Balto, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S Wade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Balto., MD 21201 23a. Part | Enter the diseas , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Ca (Final disease or condition resulting in death) Atheroscleratic Heari **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month 5 Other (specify) P.0. cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 V nknown Completed) i Sea 24a. Was an Ulmow ARy 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 □Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2X ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Drath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifie 0005455 30 Name and address of person who ompleted cause of death (Item 23a) (Type, Print) SINAI HOSPITAL of BALLMORE BURKE, JR MO 31. Date filed (Month, 'Day, Year)" 32. Engistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ McDouga1 Patterson May DeWitt 2011 5:35 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Collington Episcopal Life Care Ctr. Mitchellville 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. July 19 Year. 1**X** M 2 □ F Days Hours 93 214-34-6659 Director Tennessee Usual Residence of Decedent show 10a, State 10d Inside City Limits 10c. City. Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at the Maryland Director 1 ☐ Yes 2 🛣 No Prince George's Mitchellville MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 Funeral 10450 Lottsford Rd. #2015 20721 United States filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1XXYes 2 \(\subseteq \) No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify. Specify: Year or Dates. 1939-60 "natural" Completed 3 X Widowed 4 Divorced White the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) United States Navy Commissioned Officer 5+ other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental F is marked of ၉ Elizabeth Marie Keenev McDouga1 Patterson Page 1 and 2 should be Archibald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 is Malcolm D. Patterson / 13408 Valley Dr., Rockville, MD of Hean:
If item: Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Department of Important: If any injury or Chesapeake Crematory 05/19/2011 Beltsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 21. Signature of Funeral Service Licensee 20910 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Ph_sician/ METASTATIC PROSTATE CANCER resulting in death) Medical Due to (or as a consequence of) Examiner IRON DEICIENCY ANEMIA Sequentially list conditions, Examine it any, leaving to immediate cause. Enter Underlying Cause (Disease or linjury Due to joi as a consequence on LUNG MASS Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical BLADDER MASS Box 68760 attending properties for use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🗓 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 \(\sum \text{Yes} Certificate: 28d. Describe how injury occurred iniury 1 X Natural 5 Pending after death. 2 🗌 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical 29a. Certifier 1XXCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Certifying Nurse Practioner: To the best of my know within 2 To the I only one 29d. Date signed (Month, Day, Year) 29b. Signatur 29c. License number May 17, 2011 D57042 address of person who completed cause death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar ANITA K. CLAYTON M.D.

31. Date filed (Month, Day, Year) NAY 2 0 201

32. Registrar's Signature

1221 MERCANTILE LANE, LARGO, MD

20774

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month John Perry Reese 19, 2011 6:20 A. M May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Genesis Elder Care-Homewood Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. Sex 1 M 2 □ F 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 215-12-8124 Director 90 Jan. 21, 1921 Baltimore, MD. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director N/A Maryland Baltimore 10e. Street and Number 10a. Citizen of What Country? 10f. Zip Code 6000 Bellona Ave. 21212 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?
1 Ares 2 No. Army
If Yes, Give Air Force
Year or Dates: W.W.II Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: White 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Aero Space Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Aero Space Engineer Industries 12 04 other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental Fisher is marked of John George Reese Florence Thalheimer ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Pages 1 and 2: partment of Health a portant: If item 27 is / Injury or other trau Mrs.Laurie M.Stenger (Daughter) 3941 Old Rocks Road Street, Maryland 21154-1203 Baltimore, Friday 20c. Location - City or Jown State (Harford County) 20a. Method of Disposition Exace Fureral Carel and 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or May 20, 2011 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cremetion Services, Inc. 21. Signature of Funeral Service Licensee Jeffrey L.Cair, Sr. CISP. Name and Address of Facility

Perceful Alternatives Funeral and Oremetican Center, P.A.

Lic. #M00677 2325 York Road Timonium, Maryland 21093-2215 gair, R. 23a. Mrt1. Enter the distribution state caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last tue to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Ponknown 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy performe death? 1 ☐ Yes certificate 2 No 1∐ Yes 2 No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 5 Pending investigation Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. the 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) 0

State Registrar

Name and address of

31. Date filed (Month, Day,

20

DHMH 17 Rev 1/2001

m·n.

on who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Wood

11-03700 Davon Randolph Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

avon Kandolph		State Of Maryla I- For State Registrar		ificate of Dea			ZUII Reg. No.	16236
Physicia	n/	Decedent's Name (First, Middle,Last)				2. Date of Dea Month	ath Day Year	3, Time of Death 0644 hrs
Medical Exami	ıer	DAVON ANDRE RANDOLPH 4a. Facility Name (if not institution, give street and nu	mber)	4b. City	, Town, or Location	May 17, 2	2011 4c. County of Deal	
		Johns Hopkins Bayview Medical Cent	-		imore			
Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 M 2 F	7. Age (In yrs. las 20	t birthday) If Un Mon Yrs.			irth(MM/DD/YYYY) 9. Bi Forei -1990 C	
any	H	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location				10d. Inside City Limits
and f show	5	MD		BALTI	MORE			1 X Yes 2 No
th the Maryland 23a or 28a-f sho	Director	10e. Street and Number			ip Code		10g. Citizen of What Co.	untry?
s 23a o		3405 DUDLEY AVE. 11. Marital Status 12. Was Dec	edent Ever in U.S		1213 dent of Hispanic Or	igin? (Specify Yes or No	U.S.A. o- 14. Race - Ame	rican Indian, Black,
death v	Funeral	1 Never Married 2 Married Armed Fo	2 X No	If Yes, spe	cify Cuban, Mexica	n, Puerto Rican, etc.)	White, etc.	
s after iral", o	2	Widowed 4 Divorced If Yes, Give Yea or Dates: 15. Decedent's Education (Specify only highest grade)		1 Yes	2 X No specify		Specify: B]	LACK
2 hour	eted	Elementary/Secondary (0-12) College (1			orking life. DO NO		Tob. Kind of Business	windustry
1036 vithin 72 hc ene. er than "m Medical Es	Completed	12 2		STUI			EDUCATION	ON
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Last)				er's Name (First, Middle,		
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Montal Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she trammatic event, the Medical Examiner must be notified at once		DAWAYNE RANDOLPH 19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Addre		DREY V. DUN mber or Rural Route Nu	mber, City or Town, Stat	e, Zip Code)
and 2 shou fealth and N tem 27 is n traumatic		LORETTA ERVIN/GRANDMOT 20a. Method of Disposition		3405 DUD		BALTIMORE,	MD 21213 20c. Location - City of	r Town State
Baltimore, ME permit. Pages 1 and 2 s Department of Health as Important: If item 27 injary or other traum		1 X Burial 2 Cremation 3 Removal fr	om State cre	ematory or other plac	e)			
Iltim nit. Pag artment ortant	-	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	MOS	T HOLY REI			l BALTIMORE FY FUNERAL	
Dep Dep ii.i.		Dar ban CS		1206 1	J. NORTH	AVE. BALTIN	MORE, MD 21:	217
Physician	7	23a. Part I. Enter the disease, or complications that confailure. List only one cause on each line. Car	diac arr	hythmia d	ue to car	cardiac or respiratory ar diomegaly	rest, shock, or heart with mild	Approximate Interval Between Onset and Death
Examiner	ı		consequence of):	hypertrop	hy			- Death
		Sequentially list conditions, b						
	in in	cause. Enter Underlying Cause	consequence of).					
ecuted and and transit	Exa	events resulting in death) Last Due to (or as a d.	consequence of):					
io, e be exect ysician an burial - tr	Medical Examiner		3a,27,pe	r me,g917	7-25-11	sm		
760, ficate be g physici the buri		IF FEMALE: 23c. If yes, 1 Live b	outcome of pregna		h 3 Ecton	ic pregnancy	23d. Date of delive Month	ry Day Year
Box 6876 death certifical he attending ph	Physician/I	past 12 months?	ant at time of deat			no programoy		
). BC the dea by the a	Phy	Part II. Other significant conditions contributing to		sulting in the underlying	ng cause given in P	art I. 23e. Did t	tobacco use contribute to	o the cause of death?
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and applicitly filled in by the funeral director, page 2 should be detached for use as the burial - trans	<u>a</u>						es 2 No 3 Pro	obably 4 🗹 Unknown
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Rec(The lar	E					1 ✓ Yes	ormed? death? 2 No 1 V	
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of Ving Physical Colored Color	ے ا	27. Manner of Death 28a. Date		28b. Time of Injury	28c. Injury at Wor		how injury occurred	
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Divisi	Certification:	Suicide Could not be determined (Specify)	∍ of Injury - At hon	ne, farm, street, facto	ry, office building, e	etc. 28f. Location or Town,	(Street and Number or R State)	tural Route Number, City
Do the Hospital within 24 hours Fo the Funeral completely filled		29a. Certifier (Check only 1 Certifying Physician: To the bes						
To the Ho within 24 h To the Fu completely	Medical	one) 2 Medical Examiner: On the basis and manner s						
	Σ	29b. Signature and title of certifier	/	2	9c. License number O.C.M.E.	DOME	29d. Date signed (Mi	onin, Day, Year)
d)	ŀ	30. Name and address of person who completed cause	selet death (Item)	23a)				
γ		Theodore M. King, Jr., MD. Assista	int Medical Ex	kaminer 900 V	V. Baltimore St	reet, Baltimore, M	D 21223	
St Regist	ate	31. Date filed (Month, Dan Year) 32. Re	egistrar' Signatu	ares				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registra Certificate of Death 1. Decedent's Name (First_Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4: 00 ma 01 Medical 4a. Facility Name (if not institution. give street and number **Examiner** 4c. County of Death HOSPICE Jose NIA ermore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. (Month, Day, V . Social Security Number last birthday, 9. Birthplace (State or Foreign **Funeral** 217-66-5890 1 M 2 D F Country) Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director NIA ma Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral to leigh death v Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) d Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of gemetery, crematory or other p 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State dallstown many 4 Donyfion 5 Other (Specify) . Signat of Funeral Arvio LITON 22 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part / Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence disease or condition resulting in death) MONIDIADO Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) sician and burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician I for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records. Completed 2 No 3 Probably 4 Unknown page 2 should has been Simms 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertons: er autopsy perform 1 Tyes funeral director, or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner' ITOSPICE ျှ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral 1 Natural 5 Pending 1 🗌 Yes Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 13.2011 SHEN, DO HOO 62554 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 CYNTHIA Dn Hospice

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY Physician/ 18° MARY P. SIMPKINS 2011 9:36 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE STELLA MARIS HOSPICE TIMONIUM If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Hours 9/21/1937 MARYLAND 73 Director 218-34-2286 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State hours after death with the Maryland Director 1 🗆 Yes 2 🖔 No PARKVILLE MD BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō or than "natural", or items 23a or the Medical Examiner must be Funeral 21234 USA 9622 MASON AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. by 1 Never Married 2 Married Yes 2 X No 5-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give 3 X Widowed 4 Divorced WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Baltimore, Maryland 2121 other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene is marked other tha OWN HOME HOMEMAKER 12TH GRADE other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည DENNIS SHANAHAN EVELYN BOWEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. JOPPA, MD 634 BALDWIN DR. 21085 JOSEPH VINCENT/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 18, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH 5/21/2011 PARKVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur 22. Name and Address of Facility MO1139 THE JOHNSON FUNERAL HOME, P.A. 50 al 8521 LOCH RAVEN BLVD. TOWSON, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events and I-transit Exami Due to (or as a consequence of): resulting in death) Last physician a the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) Live Birth 2 1 results 2 Pregnant at time of death
Unknown in the past 12 months? Month Day Year 9 Unknown SIMPKINS is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has funeral director, page 2 performe 2 No Yes 2 X N 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending injury **X** Natural 5 Pending A Function 2 from 1 to 24 hours after deaun.

The Funeral Director: Aff 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State

within 2

29b. Signature ar

JONES,

CRNP

Registrar

2300 DULANEY VALLEY RD.

coursed at the time, date and place, and due to the cause(s) and manner as stated

TIMONIUM, MD 21093

18

12011

3 X Certifying Nurse Practioner: To the best of my knowledge, death of

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 12:45рм 16° 20 11 1 Thelma Mae Schwindel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death towson **Examiner** Baltimore Gilchrist Center 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 27, 1929 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 214-24-8722 1 M 2 J 81 Yrs. Director Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Baltimore Essex 28a-f 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 21221 611 Senna Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) own home traumatic event, the Homemaker 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I 1 and 2 should be file of Health and Mental fitem 27 is marked of Lene L. Kube ပ Milton C. Orvis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town State Zip Code) 2614 Clayton Road Joppa MD 21085 Sharon Goetz / daughter Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Baltimore MD 5/19/1 H6Tery cremary 1 ot Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of uneral Service Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Re current Colon cancer ren disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural injury work?
1 Yes 2 No 5 Pendina Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number le 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Part 31. Date filed (Month, Day, Year)

MAY 2 0 2011 32. Registrar's Signature State ack Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 26 per doc 9915 5-20-11 vt.

State of Maryland / Department of Health and Mental Hygiene? State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 1459 13,2011 Jean L. Schmidt May M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Union Memorial</u> <u>Baltimore</u> If Under 1 Year 7. Age (In vrs. last hirthday) 8. Date of Birth **Funeral** If Under 24 Hrs 9. Birthplace (State or Foreign 1 □ M 2 F 2-16-1931 Yrs Maryland Director 216-24-6763 80 Usual Residence of Decedent show 10a, State 10b. County and 2 should be filed within 72 hours after death with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Md. Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 4524 Parkside Drive 21206 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 No Specify: 3 XWidowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Personnel/ Payroll State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lours Layfield Barbara Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Shek DTR. 1802 Fallstaff Road BelAir, Md. 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 g 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Parkwood 5-17-2011 Parkville, Md. 4 Donation 5 Other (Specify) 21. Signature of Fundamental Service In Inc. Schimunek Funeral Home 22. Name and Address of Facility 9705 Belair Road Nottingham, Md. 21236 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) rdia Medical Due to (or as a onsequence of) Examiner orther Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 Z 2 **X**No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 24 hours after death. Funeral Director: After this cer Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျ 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centrying Nurse Practionar To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centrying Nurse Practionar To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 2011death (Item 23a) (Type, Print) 30. Name and address of person who do 31. Date filed (Month

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05-18-2011 345 A Earlaine Elizabeth Simms Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Autumn Assisted Living Bel Air Birthplace (State or Foreign Country) MTD . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex Funeral 1 🗆 M 2 🗓 F Days Hours 04409-1918 95 MD Director 215-01-6784 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2X No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 7272 Conley St 21224 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Mamied þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White If Yes Give permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exan 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Operator AT&T 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Wirth Newton C. Coster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7272 Conley St Baltimore, MD 21224 Garry M. Simms (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 05-20-2011 Atlantic Crematory Glen Burnie, MD 4 Domation 5 Other (Specify 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 21. Signat & of Funer ervis Licensee Inc 610 W. MacPhail Rd BelA

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final h sician/ end stay disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed sorlie gluways 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1331161 Other: 4 Nursing Home 5 Residence 2 ပ 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03352 15,201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) NAY 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Michael Stein 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 17, 2011 Medical Examiner 1256 hrs Michael P. Stein 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rosedale **Baltimore County** 9565 Devonwood Court 5 Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Hours Months Days Director March 29,1952 Country) Maryland 213-58-2641 1 X M 2 F 59 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location III 1 Yes 2 No show Rosedale Md. Balto. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9565 Devonwood Court 21237 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 Married 2 X No Yes f Yes, Give Year 3 Widowed 4 X Divorced 1 Yes 2 X No specify: White þ 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Shipping Clerk Stationary Business Itimore, MD 21215-0036 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Irene Marchsteiner Harry Stein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nottingham, Md. 21236 9111 Bowline Road Shirl DeCerbo 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 5-19.2011 Glen Burnie, Md. 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 23a, pt.II, 27, per me, g915 amend 26, per me, g915 5-25-11 s X UNPENDED 5-25-11 sm e attending physician for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Month Live birth 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 V Unknown Chronic alcoholism, methadone use Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate has death? 1 ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other Scene ER/Outpatient 3 DOA 1 V Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 1 Yes 2 No after death.

Director: A in by the fi 5 Pending 2 Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DOME May 18, 2011 O.C.M.E. 30. Name and address of person who complete buse of de th (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Pate filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b perFH, G915, 5/2072011, WS
State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ORG Medical 4a. Facility Name (if not institution) give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 50TH 57. D Sex 1 M 2 D F 7. Age (In yrs. If Under 24 Hrs 8. Date of Birth last birthday 9. Birthplace (State or Foreign **Funeral** Min. (Month, Day, Months Hours Country 3-0 Yrs Director Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Merical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 5 : A SII 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 Yes 2 Black, White, etc. 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 Yes 2 No Specify: WHITE 3 ₩idowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11167 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mb. BALTO 0 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State AKLAUN WID 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Fromos KANDM 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eni Dementiq ₹nysician/ 2 disease or condition resulting in death) years Medical Due to (or as a consequence of) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 Yes 2 No 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔲 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completed filled in by the funeral 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a."Date of injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide within 24 hours are deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c, License number d (Month, Day, Year) IND D083389 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3760 filed (Manth, AY 2 () Day, Year) State

Registrar

Examiner Anne Arundel Linthicum Tate Hospice House If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month) Days Hours Min. May 10, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F 220-28-0507 77 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be rotified at once. 10c. City, Town or Location 10b. County 10a, State Easton Director MD Talbot 10g. Citizen of What Country? 10f. Zip Code 21601 10e. Street and Number 28503 Pinehurst Circle Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □XNo Specify: Specify: þ 3 N Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 pharmacy clerk pharmaceutical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Ellen Moore Earle Bateman Wood ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8217 Brooktree St; Laurel, MD 20724 William Turner - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature of Emeral Service Licensee ROITa Ld Wards Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final isamor **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** do cept Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month 5 ☐ Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one 1 Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death

Director: A

d in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

and manner stated.

May_M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. Decedent's Name (First, Middle, Last)

Suzanne Turner

4a. Facility Name (If not institution, give street and number)

Physician

/Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per verb 9915 5-20-11 yet State of Maryland Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death Month

May 10,

2011

4c. County of Death

11:20 PM

Maryland

White

Approximate Interval Between Onset and Death

Year

29d. Date signed (Month, Day, Year)

10d. Inside City Limits

1 ☐ Yes 2 No

Registrar DHMH 17 Rev 1/2001

State

(Check only one)

31. Date filed (Month

29b. Signature and title of certifier

D39505

Kan 305 Hospital Dr, Glen Burnie, MD. 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month WANJE RICARDO VANEGAS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOSPITA PRING UER JTGOMERY MOA If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 M 2 D F Days (Month, Day, Months Hours Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Dyes 2 DNo HYMA 10e, Street and Numbe 9 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 610 AVE 2 PO SVA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, and 2 should be filed within 72 hours after deal Health and Mental Hyglene. Hem 27 is marked other than "natural", or iter Yther traumatic event, the Medical Examiner. Black, White, etc. 1 Never Married 2 Married Completed by 1 Pryes 2 No Specify: EL SALVADOR Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced MHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) INFANT WARRIOI Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ٩ ROSA ANTONIO VANEGAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOSPITAI GLEN HOLY CLROSS 200 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1:
Department of I
Important: If it
any injury or or ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board Le, Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final APNEA-RESPIRATORY FAILURE Physician/ disease or condition Medical resulting in death) Examiner NENCE PHA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): PREMATUR 2 WK-GEST Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 No 9 Unknown p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law this certificate has al director, page 2 performed Yes 2 🗹 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending Accident Suicide 1 Yes 2 No Investigation within 24 hours after death To the Funeral Director: / completed filled in by the I Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D004671 necuaw, m

Registrar
DHMH 17 Rev 7/2009

State

SHARON

31. Date filed (Month, Day, Year)

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POREST

COLEN RA

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KIERNAN

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

20 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MITTAL Paperal SS1 3 Watha

rah

Division of Vital Records, P.O. Box 68760

Waltham

29c. License number

P0069314

29d. Date signed (Month, Day, Year)

Wood Rd Pennentle MD 21234

11-03685
Bryant Walker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 i

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	1- For State Registrar	Cei	rtificate of Death	Reg. No.	
Physician/ Medical Examine	1. Decedent's Name (First, Mic	J. Walker		2. Date of Death Month Day May 16, 2011	Year 3. Time of Death 0912 hrs
	4a. Facility Name (if not institu Johns Hopkins Hosp		4b. City, Town, or Location Baltimore	N	County of Death
Funeral Director	5. Social Security Number 204 54 2607	6. Sex 7. Age (In yrs. I	last birthday) If Under 1 Year If Unde	``	DD/YYYY) 9. Birthplace (State or Foreign Country)
Varyland 28a-f show any d at once. ector	Usual Residence of Decedent 10a. State 10b. Coun MD NA	·	Town or Location		10d. Inside City Limits 1 Yes 2 No
the Maryl s or 282-1 stiffed at 0	10e. Street and Number 1810 Ruttan	d Ave.	10f. Zip Code 2/2/3	10g. Citi.	zen of What Country?
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland men of Health and Mental Hygiene. Faut: If item 27 is marked other than "natural", or items 23a or 28a-f shoor or other traumaite event, the Medical Examiner must be notified at one. To Be Completed by Funeral Director		Married 12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No 1 No 1 Yes 1 Yes 1 Yes 1 Yes 1 Yes Yes	.S. 13. Was Decedent of Hispanic Orinif Yes, specify Cuban, Mexican 1 Yes 2 No specify.	n, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
5-0036 ed within 72 hours ilygiene. other than "naturithe Medical Exami Completed is	15. Decedent's Education (S Elementary/Secondary (0-1	pecify only highest grade completed)	16a. Decedent's Usual Occupation (Give during most of working life. DO NOT NEVER WORKED		Kind of Business/Industry
21215-0036 wild be filed within 7 Mental Hygiene. marked other than a event, the Medica	Joseph Brac	le Last)	18. Mother	r's Name (First, Middle, Maiden da Walker	
MD 21 ad 2 should slith and Me m 27 is ma numatic ev	Lean Walke	er-Sister	19b. Mailing Address (Street and Nur 163-11 Foch Bl	id. Apt. 66 Jan	ity or Town, State, Zip Code) NAICA \\ \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Realth and Mental Hygiene Important: If item 27 is marked other tinjury or other traumatic event, the Mediumy or other traumatic event, the Medium of t	4 Donation 5 Other	on 3 Removal from State	Place of Disposition (Name of cemetery, crematory or other place) 21. Name and Adhress of Facilit	5-20-11 Ca	tonsville, MD
	21. Signature of Fun rai Serv	ful	Gary P. March Fl.	1 290 Fredhilte	n Pass Baffords
Physician Medical Examiner	failure. List only one cau Imme late Cause (Final disea or condition resulting in death	se a Complications	of Subdural Hemorrh		Between Onset and Death
<u> </u>	Sequentially list conditions, if any, leading to intrinediate	b. Bleeding Intra	a-Cerebral Aneurysm		
ted that the ted t		C	of):		
760, ficate be executed g physician and the burial - transit	X UNPENDED		7,per me,g919 9-8-11		d. Date of delivery
). Box 68760, the death certificate by the attending physiched for use as the bunyalcian/Mec			2 Fetal death 3 Ectopi		Month Day Year
P.O. E es that the d	î	ditions contributing to death but not r	resulting in the underlying cause given in Pa		use contribute to the cause of death? No 3 Probably 4 V Unknown
Division of Vital Records, P.O. Box 68 and ortificate death. To Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as refification: To Be Completed by Physician				24a. Was an autopsy performed? 1 ✔ Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death? 1 yes 2 No
Vital Recysician: The Inis certificate Idirector, page			26.Place of Death		
o ಈ 🖫 💈 🔁	1 Yes 2 No			Nursing Home 5 Reside	
on of cending P sath. or: After the funeration:		28a. Date of Injury (Month, Day,Year) ending vestigation	28b. Time of Injury 28c. Injury at Worl	.	ury occurred
Division o Bopital or Attending A hours after death Funeral Director: Aftered filled in by the fune all Certification:	2 Accident In 3 Suicide 6 C 4 Homicide	ould not be etermined (Specify)	ome, farm, street, factory, office building, e	tc. 28f. Location (Street a or Town, State)	and Number or Rural Route Number, City
Division of Vita To the Hospital or Attending Physicia within 24 hours after death. To the Funeral Director: After this ce completely filled in by the funeral direct Medical Certification: To Be		Physician: To the best of my knowled xaminer:On the basis of examination and manner stated.	dge, death occurred at the time, date and pl and/or investigation, in my opinion, death o	ace, and due to the cause(s) ar	nd manner as stated. ace, and due to the cause(s)
	29b. Signature and title of cer		29c. License number O.C.M.E.	·	Date signed (Month, Day, Year) y 19, 2011
	30. Name and address of pers	on who completed sause of death (Iten	n 23a) miner 900 W. Baltimore Street,	Baltimore, MD 21223	
State Registra	e 31. Date filed (Month, Day, Ye.				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year NORMAN J. WHITNEY 270AM Medical 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNION MEMORIAL HOSPITAL BALTIMORE CITY 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign Days 1 🕅 M 2 🗆 F Months Maryland 218-22-3517 83 **Director** Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f Dunda1k 1 Yes 2 No MD Baltimore Co. 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? items 23a Funeral 21222 8126 Dundalk Avenue USA hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 5 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: If Yes, Give Year or Dates. Korea "natural", Completed 3 X Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel N/A Welder and Mental Hygie is marked other event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (UNK) ည John Whitney Eleanor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Brenda Reed-Friend 8126 Dundalk Avenue Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 5-19-2011 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA MD 21222 1201 Dundalk Avenue Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Coronar Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immedi cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death ed by the a detached f 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe After this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Dea 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pendina work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nyrse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 20/ 30. Name and address of person who ted cause of death (Item 23a) (Type, Print) nion 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

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egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ May 11.2011 Myrtle Irene Wicker 5:12P М Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8901 Carlisle Avenue Nottingham Balto. If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 Months Hours June 11, 1928 163-24-7631 **Director** 82 Pennsylvania Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director Md. Balto. Nottingham 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8901 Carlisle Avenue 21236 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status Race - And Black, White, etc.
White 14. Race - American Indian Armed Forces?

1 Yes 2 No 1 Never Married 2 Married þ 1 ☐ Yes 2 No Specify If Yes, Give 3X Widowed 4 □ Divorced Specify. Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Restaurant Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Klinedinst Hershel Krout Maize 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Mace Son 2229 Monocacy Road Essex, Md. 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Memorial 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Glen Burnie, Maryland 4 Donation 5 Other (Specify) 5-16.2011 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or impury Examine Due to (or as a consequence of) Cause (Disease or ii that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Suicide 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHMOOD, 2300 DULANEY VALLEY RD. MD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) MAY 20 State Registrar

DHMH 17 Rev 7/2009

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 🤈 🦳 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05-17-2011 500 A Susan Gayle Webster Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Hours Min 1000821961 49 212-78-2330 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location Director Harford Bel Air 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21014 USA 200 Princeton Lane hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married 5-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Fast Food Rest. 12 Manager 27 is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked to any injury or other traumatic ever once. 2 Casimir Oleszczuk Helen Luckert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Princeton Lane BelAir, MD 21014 Gary Webster (Husband) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 05-18-2011 Glen Burnie, MD 21. Signatus of Funeral Society ensee Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Lung Cancer Medical resulting in death) Due to (or as a consequence of): **Examiner** 23 month metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the bunal-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Dav Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown been signed by the a should be detached to g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 s has autopsy this certificate funeral director, 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No မြ 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injury 1 Natural 5 Pending 24 hours after death. Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the Vithin 2 only one) 29d, Date signed (Month, Day, Year) Medical Doctor D71096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ESTADILLA 500 Upper Chesapeaka Drive Bel Air MD 210/4

Registrar DHMH 17 Rev 7/2009

State

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		4a. Facility Name (if not inst Baltimore Washing					4	b. City, Town, or L Glen Burnie	ocation of L	Death			County of Deat ne Arunde	
-		5. Social Security Number	6. Se			rs. last birthda	av)	If Under 1 Year	If Under 2	24Hrs 8	B Date of Birt			rthplace (State or
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e, MD 21215-0036 1 and 2 should be filed within 72 Health and Mental Hygiene. Filem 27 is marked other than "		Sharen C	lark	/moth				orest F						
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Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27		21. Signatur of Funeral Se	vice Licen	1909	/	2	22. N	ame and Address o						lto. MD
	\dashv	23a. Part I. Enter the diseas	e, or comp	lications that ca	used the d	eath, Do not e	nter th	Connell be mode of dying, s	Ly Fu such as card	iner	al Ho	me of	OI ES:	Sex 21221 Approximate Interval
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68760 riffcate ling phys	2	IF FEMALE: 23b. Was decedent pregnan	in the	23c. If yes, o		pregnancy 2	Fet	al death 3	Ectopic p	regnanc	/		Date of delive Ionth	Day Year
Box 6876C death certificate the attending physical for use as the b	sicia	past 12 months? 1 Yes 2 No 9	Unknowr	. '	ant at time	of death 5	Oth	ner (Specify)						
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/ital	Be	examiner?	Ti-	Hospital: 1	npatient 2	2 ✓ ER/Outp	atient	10				Residenc	ce 6 Oth	er:
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Division of Vital Records, P.O. Box 6876C. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier 1 ☐ Certifyi (Check only one) 2 ✓ Medica	ng Physic Examine	ian: To the bes r:On the basis o	t of my know of examinati	wledge, death ion and/or inve	occuri estigati	red at the time, date ion, in my opinion,	te and place death occu	e, and du rred at th	e to the cause ne time, date a	e(s) and and place	manner as sta e, and due to t	ated. the cause(s)
To t com	Medical	29b. Signature and title of c		and manner st		100	21	29c. License		_				onth, Day, Year)
		9/5 the	1/2	6/	of the	1908	U	O.C.N				May	14, 2011	
→ ★	-	30. Name and address of po	erson who	completed caus	e of death	(Item 23a)					,			
Ψ	l	Victor Weedn MD		ssistant Me			00 W	. Baltimore St	reet, Bal	timore	, MD 2122	3		
	ate	31. Date filed (Month, Day,	'ear) ◀	32. Re	gistrar's Sig									
Regist	rar	MAY 2 U 201	1	A server	7.	parks								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20^{Day} 2011^{Year} Physician/ Month May Barbara J. Arnett Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brinton Woods Health Care Center Carrol1 Sykesville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 20 1930 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 CT **Funeral** Min. 1 🗆 M 2 🔀 F Hours CT 81 Director 047-22-7184 Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD Howard Ellicott City 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3020 N. Ridge Road # 106 21043 USA death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: white Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ye 1 and 2 should be filed within 7% t of Health and Mental Hygiene.

If item 27 is marked other than Elementary/Seconday (0-12) 2^{College (1-4 or 5+)} the purchasing agent education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Clarence Jacobson Margaret Noonah traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3020 Wheatfield Rd., Finksburg, MD 21048 Susan Boylan (daughter) Baltimore, other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State ö Department of Important: If any injury or once. Garrison Forest Vet. 5-31-11 Owings Mills, Md Donation 5 Dother (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Funer Service License P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ nayfo disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examir or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical P.O. Box 68760 38 attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months Day Pregnant at time of death the Unknown g 🗌 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perform death? certificate 2 - NO Yes 25. Was case referred to medical Be 26. Place of Death_(Check only one) examiner? Other 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural
2 Accident
3 Suicide 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes hours after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral Completed filled To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practimer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date skinned (Month, Dav. Year) 2011 nd address of person who completed cause of death (Item 23a) (Type, Print) 21136 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 04,30AM 301 e12 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 8. Date of Birth (Month, Day Year) 07-15-1950 Birthplace (State or Foreign Country)
 Magazil and 5. Social Security Number 7. Age (In vrs. last birthday) Days 1 X M 2 - F Maryland 70 220-48-0422 Usual Residence of Decedent 10d. Inside City Limits 10c City Town or Location 10a. State 10b County 1 X Yes 2 □ No Baltimore N/A Maryland 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? USA 21206 4920 Belair Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes If Yes, Give 1 X Never Married 2 Married 1 ☐ Yes 2 💢 No Specify. White Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Barber Shop Barber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clifford Miller Pearl Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21212 1004 Upnor Road Catherine Maggitti - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial ✓2 ☐ Crem emoval from State 05-23-2011 Baltimore, Maryland Parkwood Cemetery 4 Donati 22. Name and Address of Facility 5305 Harford Road 21. Signat Leonard J. Ruck, Inc. Baltimore, MD 21214 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ons that caused the death.

Physician /Medical Examiner

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page

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neral Director; Af
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within 24 hours a

To the Funeral C

completely filled the Hospital

Mec

State

29b. Signature and title

Rina Khatri, MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Department of Health ar Important: If item 27 Is any injury or other trau

Physician

/Medical

Examiner

Funeral

Director

ms 23a or 28a-f show must be notified at

items 23a

th and Mental Hygiene. 7 Is marked other than "natural", or iter traumatic event, the Medical Examiner.

Directo

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

	shock, or b a failure. List on you	ne cause on each line.	Interval Between Onset and Death
	disease or condition resulting in defin)	a. Due to (or as a consequence of):	
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b	
	resulting in death) Last	Due to (or as a consequence of): d	
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
þ	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Completed			autopsy periormed? Pres 2 No 1
0	25. Was case referred to medical	26. Place of Death (Check	only one)
To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5	Residence 6 Other (Specify)
	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury Work?	scribe how injury occurred
Certification:	3 Suicide 6 Could not b 4 Homicide determined		ation (Street and Number or Rural Route Number, or Town, State)
ical C		ysician: To the best of my knowledge, death occurred at the time, date and place, and due niner: On the basis of examination and/or investigation, in my opinion, death occurred at the	

29c. License number

29d, Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BAYER Joi1 KATHERINE 10:43 AM MAY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CENTER NORTHWEST HOSPITAL Baltimore Randallstown If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 8. Date of Birth (Month, Day, Sept 20 7. Age (In yrs. last birthday) 1 □ M 2 □√F 91 1919 Sept 220-34-6963 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □ Yes 2 PNo Windsor Mill Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **USA** 21244 3117 Rices Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Specify: white 1 □Yes 2 VNo Specify If Yes, Give Year or Dates: 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) clerical 11 secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Kelly Katherine Finkbeiner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7852 Elizabeth Rd., Pasadena, MD 21122 19a. Informant's Name/Relationship (Type. Print) Hohman Bayer Jr. (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial 5-25-11 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Parge Haight Herbert P.O.Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EMBOLISM. PULMONARY Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Day Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERY CORONARY 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

Be

Funeral

Director

item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be inclined at

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If fiem 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Exercities once.

Baltimore, Maryland 21215-0036

and burlal-trar attending physician for use cate has been signed by the page 2 should be detached certificate

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours after death. After this of funeral dire

Examiner Physician/Medical þ Completed Be Certification: To

Medical 29b. Signature nd title of certifier

5 Pending investigation

6 Could not be

determined

CARDIO MYOTATHY

25. Was case referred to medical

1 Yes 2 No

examiner?

27. Manner of Death 1 Natural

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

29c. License number

D 4 1723

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 2011

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

autopsy performed? Yes 2 700

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A YVERA HALLI

L-ARION HARISH

SHOI OLD COULT RANDALLSTOWN

State Registrar 1 Inpatient

28a. Date of Injury (Month, Day, Year)

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Physician /Medical Examiner **Funeral** Director Director Funeral ģ Completed Be ည Physician) /Medical **Examiner**

I physician and as the burial-transit or Attending Physician; The law requires that the death certificate be executed Box 68760, P.O. of Vital Records, page s after death. I Director: After t Division

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2011 8 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 1 🖾 M 2 🗆 F 7,1949 Maryland 61 Yrs Nov. 218-58-4870 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits Edgemere 1 ☐ Yes 2X No Baltimore MD 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number United States 2 Short Lane 21219 Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 **∭**No 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: 3 Widowed W Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Installation 9 Years Pipefitter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carolyn Wenker Becker <u>Jose</u>ph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)Former 21219 Edgemere, Maryland 2922 Wells Ave. Sandra Becker-Thorn 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Dundalk, Maryland Sacred Ht. of Jesus Cem. 5/23/2011 4 Donation 5/5 Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of 7922 Wise Ave. Dundalk, Maryland 23a. P 11 nter the disease, or complificions that cause Approximate Interval Between The death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each ne. Onset and Death Immediate Cause (Final 8 hours resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗌 No 1 Tyes 1 Tyes 2 - No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 4 Aven4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, 32. Registrar's Signature MAY 23 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001 11595

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month SIDDP M Virginia Ε. Bargar Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Glen Burnie Baltimore-Washington Med Ctr. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🕱 F Days Min. Hours June 19, 1926 Virginia Yrs 230-28-0244 84 **Director** Usual Residence of Decedent 28a-f show i Hygiene. I other than "natural", or items 23a or 28a-f shov vent, the Medical Examiner must be notified at with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 201 Magothy Beach Road 21122 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐ Yes 2 🗷 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Accounting Department <u>Baltimore Aircoil</u> Be Department of Health and Department of Health and Mental H
Important if item 27 is marked off any injury or other traumatic con-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jesse James Giles Ethe1 <u>Hamilton</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry L. Williams (Daughter) 7814 Edgewood Avenue Pasadena, Maryland 21122 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Glen Haven Mem. Pk. 105/26/2011 4 Donation 5 Other (Specify) Glen Burnie, Maryland 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? After this certificate 2 No 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tyes 2 LANO မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 \square Homicide Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Turse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 DWUSM BUR

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year

Amend Item 25 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 = State Amend Item 23a per dr.,g915,05/23/2011dhb

Reg. No. 2 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Sylvia B. Brown May 2011 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Sinai Hospital of Beltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yes 10–15–1919 **Funeral** 1□M 2XF Months Hours **Director** 219-22-8474 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location items 23a or 28a-f show 10d. Inside City Limits Director 1XYes 2 □ No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4803 Tamind Road, Apt. 424 21209 Funeral USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedon. _ Armed Forces? 1 □Yes 2 X No ient known as: Sylvia permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Modical Examinations. 1 ☐ Yes 2 If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 【No Specify: Specify: African-American Completed by 3 X Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Charles Byrd Ellen Harris 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda S. Koonce/Dauchter 127 Farmington Lane, Henderson, NC 27537 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakeview Memorial Park 5-14-2011 Sykesville, Maryland 21. Signatule of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1 Inter the disease, or complications that caused 1 e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each list. **Complications of Hypertension** Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Unspecified Natural Causes **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes - 2 1 No 1 Inpatient 2 ER/Outpatient 3 IDOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After t 28d. Describe how injury occurred 5 Pending investigation 1 Natural 24 hours after death. Funeral Director; A 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) To the I within 2. 29b. Signature and title of certifier 29c. License number May 7, 2011 D59062 7.0. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W Checker Beltimore MA 21215 Hansa M.D. 2401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Gener B. Jake Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per PHY C915 5/23/2011 JH State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	- Otate (or iviai	•		cate of D			Reg. N		West and the second	16280
Н	Physicia	an/	1. Decedent's Name (First, Midd	,						2. Date of De Month	eath			3. Time of Death
den.	Medi	cal	MARY BIRN 4a. Facility Name (if not institution		MARY	BRUM	45	Oit Tour	l	MAY	20		1	5:55 A M
1	Examir	ier	7615 SEVEN 1	_	nber)			BALTIM	Location of Dea	itin	41	c. County of De BALTI		E.
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ XF	-	n yrs. last birth	day) If L	Inder 1 Year	If Under 24 Hr Hours Mir			9. E		ice (State or Foreign
	Director		060-40-5382 Usual Residence of Decedent	I LI IVI Z LANF	3	39 Y	rs.	Buyo	Tiodis IVIII	01703	7192	22	Journa	POLAND
	show show	5	10a. State 10b. Count	ty	11	Oc. City, Town	or Location						100	d. Inside City Limits
	Maryl 28a-f otifie	Director	NY	QUEENS		FLUS	HING							1 🗆 Yes 2 No
	th the		10e. Street and Number				10	f. Zip Code			10g. C	itizen of What	Countr	y?
	must	Funeral	141-52 73RD A		and and Free	.:110	40 144 0	1136		2 - " \ \ - \ \ \		USA		
ယ	or ite	by Fi	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	12. Was Dec Armed Fo arried 1 ☐ Yes	orces? 2 X No	rin U.S.				Specify Yes or No- rto Rican, etc.)		14. Race - An Black, Wh		
003	ırs aft ural", I Exal	ed t	3 XWidowed 4 ☐ Divorce		ve		1 🗆 Y	es 2 🕅 No	Specify:			Specify:	WH	ITE
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed		dent's Education hest grade completed)	1 (Give kind o	Usual Occupa f work done di	ition uring most of wo	orking	16b. I	Kind of Busines	s Indu	stry
12	within ? /giene. rer than t, the M	Con	Elementary/Seconday (0-12)	College (I-4 or 5+)			T use retired) MAKER				OWN HO	ΜF	
pd 2	filed wall Hyg	Be	17. Father's Name (First, Middle,	, Last)			110111		18. Mother's Na	ame (First, Middle	, Maiden		1112	
ylar	should be file and Mental H is marked o raumatic eve	욘	LIPMAN	M	EITEI	LES			BLIM	A		R	OZM	ARIN
Maryland	2 should be filed within 72 hours after death with the Maryland lith and Mental hygiene. 27 is marked other than "natural", or items 23a or 28a-f show rtraumatic event, the Medical Examiner must be notified at.		19a, Informant's Name/Relation			1	-			ural Route Numbe				de)
	and Heal tem (IRVIN BRUM/S	SON		20b. Place of (STREET	, FLUSHI		NY 11:		Chaha
moi	0 5 == =		1 🕅 Burial 2 □ Cremation 4 □ Donation 5 □ Other		State	cemetery,	crematory	or other place				-		
Baltimore,	permit. Page Department Important: any injury o		21. Signature of Funeral Service			MI. HE		e and Address		20/2011 SOL LEVI		LUSHING L & BRO		
8			1956				8900	REIST		ROAD, P				21208
			23a. Part . Enter the disease, of shock, or heart failure. List	or complications that t only one cause on e	caused the ach line.	e death. Do no	t enter the	mode of dying	, such as cardia	c or respiratory ar	rest,		h	pproximate nterval Between
đ	Physician Medical	1	Immediate Cause (Final disease or condition resulting in death)	a. PA	VCR	EATIC onsequence of	, د	ANCE	C				-	Onset and Death
1	Examiner		,	Due to	(or as a co	nsequence of	1:						12	1/2 MONTHS
		Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):											1	
	and transif	xam	Cause (Disease or iinjury that initiated events	c	,								1	
	certificate be executed nding physician and use as the burial-transit		resulting in death) Last	Due to	(or as a co	nsequence of)	:							
8760	ficate g phys	Medical		d										
% ×	ndir use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou			3 ☐ Ecto	pic pregnancy			- 1	23d. Date of c	lelivery	
Вох	e death the ath	Physician/	in the past 12 mo∕ths? 1 ☐ Yes 2 No 9 ☐ Unknown		nant at tin	ne of death		r (specify)				Month	D	ay Y ear
P.O.	Physician: The law requires that the death certhis certificate has been signed by the attendinal director, page 2 should be detached for use		Part II. Other significant condit	tions contributing to a	eath but n	ot resulting in	the underly	ing cause give	en in Part I.	23e. Did t	obacco	use contribute	to the	cause of death?
ds, l	luires 1 en sign	ed by	NONE							1 🗆	Yes 2	№ No 3 □	Probal	oly 4 🗆 Unknown
Division of Vital Records,	aw require as been si 2 should	Completed								24a. Was				findings available eletion of cause of
Re	ysician: The law is certificate has director, page 2 ?			24							ormed?	death?		_
ital	sician certifi rector	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:				Othor	ce of Death (Che					on's
of V	g Physer this eral d	e: To	27. Manner of Death	28a. Date	of injury	2 ER/Outp	ne of	DOA 28c. Injury	4 ☐ Nursing	Home 5 hesti 28d. Describe I			cify)R	esidence
O	endin eath. or: Aft	Certificate:		tigation	th, Day, Ye	<i>ear)</i> inju	ary M	work?	'es 2 □ No		Í	•		
1									28f. Location (S City or Tox			u <i>ral R</i> e	oute Number,	
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as sta										tated				
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director. After this completed filled in by the funeral director.	29a. Certifier (Check only one) 1 Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										(s) and manner stated. d.		
	To t		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									(, Year)		
			20 Name and address of some		Esso.		. 51 "	D006:	2766		MA	y 20	20	11
+			30. Name and address of person Row SAMET					ST 0	ALTIM	ORE N	D	2120	1	
	Stat	е	31. Date filed (Month, Day, Year) WAY 2 3 201	32. R	egistrar's	GREE! Bignatur	11		.,	- 1		- , , , ,	,	
	Registra	l.	IIII A J LUI	- Marian	· Ju.	17 20	-							

State of Maryland / Department of Health and Mental Hygieney

Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 05 20 Doughney, III 2011 02:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8101 Bellona Avenue Unit 5 Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/01/1940 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**⊠** M 2□ F 217-38-1110 70 MD Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or Iteme 23a or 28e-f ehow other traumatic event, the Medical Examinar hust be notified at 1 ☐ Yes 2 X No Baltimore **Funeral Director** MD Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21204 8101 Bellona Avenue Unit 5 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: if Item 27 ie marked other then "naturel; or ite mury or other traumatic event, the Madical Esserinia ury or other traumatic event, the Madical Esserinia 1 X Yes 2 No If Yes, Give Year or Dates: 1958–66 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. Be Completed by 3 ☐ Widowed 4 🎖 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chief Mechanical Inspector City of Howard Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Doughney, II Marie Baurenfiend 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4341 Harford Road Baltimore, MD 21214 Sharon Lynn Doughney, Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment Important: If any injury o 05/23/2011 4 ☐ Donation 5 ☐ Other (Specify) Wood Lawn Cemetery Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5305 Harford Road, Baltimore, MD 21214 Approximate Interval Between Onset and Death Immediate Cause (Final † Physician disease or condition resulting in death) Chronic OBSMUCTURE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed for use as the burial-transit resulting in death) Last Due to (or as a consequence ol): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 Yes 2 No be detached P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, discuse 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA LIVING 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? PAZILITY Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

DHMH 17 Rev 1/2001

State

Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAY 23 2011

AARON

N.

6701

29c. License number

29d. Date signed (Month, Day, Year)

2011

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMOUNES MO

DHMH 17 Rev 7/2009

			St	ate of Maryland						•
			For State Registrar			tificate of L			g. No. 201	16283
	Physicia		Decedent's Name (First, Middle, Last)				_	Date of Death Month	5 ^{Day} 20 ^{Year}	3. Time of Death
	Medic	al	Fred Anthon 4a. Facility Name (if not institution, give street		ell_	4h Oit Teur a	Location of Death	May 1	5 2011 4c. County of Dea	
	Examin	er	Carroll Hospice Dove	ŕ			minster		,	roll
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y	9. Bi	thplace (State or Foreign ountry) aryland
	Director		217–28–0942 Usual Residence of Decedent	88_	Yrs.			Oct. 18,	1922 Ma	ryland
	show dat	ē	10a. State 10b. County	10c. City, To	wn or Loc	ation				10d. Inside City Limits
	Mary 28a-f	irec	Maryland Carroll			-	Windsor			1 🔀 Yes 2 □ No
	s after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at	Funeral Director	10e. Street and Number 1032 Green Valley	P.A		10f. Zip Code	21776	10	g. Citizen of What C	S.A.
	eath w	Fune	11 Marital Status 12. W	/as Decedent Ever in U.S.	13. V	Vas Decedent of H	ispanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No-	14. Race - Ame	erican Indian,
36	after d ", or i	δ Σ	1 Never Married 2 Married 1	Yes 2 X No Yes, Give		☐ Yes 2 🖾 No		incari, etc.)	Black, Whi	
00	filed within 72 hours after death with the Maryland al Hygiene and 23a or 28a-f sho d other than "natural", or items 23a or 28a-f sho evert, the Medical Examiner must be notifiled at	Completed	15. Decedent's Education			ent's Usual Occup		1	6b. Kind of Business	nite Industry
215	in 72 h e. nan "n	Jung	(Specify only highest grade con Elementary/Seconday (0-12)	mpleted) ollege (1-4 or 5+)	(Give I life. D	ind of work done of NOT use retired)	during most of worki	ng		
121	ould be filed within 72 hours ad Mental Hygiene. marked other than "natur imatic event, <u>the Medical</u> I	a	10 17. Father's Name (First, Middle, Last)			farmer	18. Mother's Name	/Eirst Middle Ma		airy
anc		전 E	William Edward Go	snell			_	Jane Cona		
Maryland 21215-0036	2 should be the and Ment 27 is marked traumatic e		19a. Informant's Name/Relationship (Type, Pr	int) 1	9b. Mailir	g Address (Street	and Number or Rura	l Route Number, C	tity or Town, State, Z	ip Code)
Σ.	ind 2 s lealth im 27 her tra		Imogene Gosnell/ wife				lley Rd.		ndsor, MD Oc. Location - City o	
Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 is any injury or other trau		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Remo	val from State ceme	etery, cren	sition (Name of natory or other place k Cemete)	:e)		ir. Marsto	
altin	nit. Pa vartme vortani injury		4 Donation 5 Other (Specify) 21. Signature of Foneral Service Licepeee	i / A/					neral Home	
ä	lm per any		(athanine).	Harlen		10 Churcl			or, MD 217	776
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau	ns that ca death. Do se on each line.	o not ente			r respiratory arrest	9	Approximate Interval Between Onset and Death
a	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	e of:	Hem	om has			ten days.
Janes,	Examiner		Commentally lies and distance	athero	ىلىء	hodis	0			years
	7 t	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequence	e of):					1
	be executed sician and burial-transit	Examiner	that initiated events c. — resulting in death) Last	Due to (or as a consequenc	e of):					
0		cal	L d							
Box 6876	Attending Physician: The law requires that the death certificate to are death. Are death. ector: Atter this certificate has been signed by the attending physics the funeral director, page 2 should be detached for use as the I	Completed by Physician/Medi	IF FEMALE:					-		
ox 6	ath ce attend for us	cian,	in the past 12 months?	yes, outcome of pregnancy Live Birth 2 Fetal de Pregnant at time of deatl		Ectopic pregnand Other (specify)	су		23d. Date of do Month	Day Year
. B	the de sy the ached	hysi	9 🗆 Unknown	Unknown						
P.O.	requires that the der been signed by the should be detached	by P	Part II. Other significant conditions contributions	ting to death but not resultin	ng in the u	nderlying cause gi	ven in Part I.	_		o the cause of death? Probably 4 🗆 Unknown
rds	equire een si hould I	eted	Sypon	Petter 1	7 -	Jena	lound	24a. Was an		utopsy findings available
ဓင္ဝ	The law rate has the page 2 s	Juno						autopsy perform	prior to ed? death?	completion of cause of
ai R	iclan: The certificate rector, pag	Be C	25. Was case referred to medical examiner?			26. PI	ace of Death (Check	1 Yes 2		Hospice
. Vit	hysici this ce al direc	၉	1 ☐ Yes 2 ♠ No	1 Inpatient 2 ER/			4 LJ Nursing Ho		ce 6 COther (Spe	
Division of Vital Records,	iding Physician: Th. th. After this certifications of tuneral director, partitions	Certificate:	27. Manner of Death 1 Anatural 5 Pending 2 Accident Investigation	Ba. Date of injury (Month, Day, Year)	o. Time of injury	28c. Injur work	y at ⟨? Yes 2 □ No	28d. Describe how	injury occurred	House
isio	Il or Attendi after death. Director: A d in by the fu	ertifi	a □ outside — c □ Could not be □	Be. Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R	ural Route Number,
Οį	ital or urs afte ral Dir		(L							lata d
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th	Medical	(Chack 2 Medical Evaminer: 0	To the best of my knowledg n the basis of examination and ctioners to the best charges.	d/or invest	igation, in my opinio	on, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.
	To the within 2 To the comple	2	29b. Signature and title of certifier	•		29c. License			d. Date signed (Mon	
	}		, kear the	C MD			38915		2/16/11	
H			30. Name and address of person who comple	FREIJI	a) (Type, F 29		ITA A	10 1100	Luinc.	wa. 4021157
	Sta	•	31. Date filed (Month, Day, Year)	32. Registraris Signature	ار ال	3 210	ver a		1 100 11 21	J-117
	Registr	ar	MALES 3 / UII / ///	und D. Cl. Collect	LICE					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Gates Mary Karen 18, May 5:53 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Baltimore Gilchrist Hospice Center Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** Months Days Hours Min (Month, Day, Feb. 2 1 □ M 2 🟋 F (1955 1955 Director North Carolina 56 240-82-5440 Usual Residence of Decedent show 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director or 28a-f 1 Yes 2 X No MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21221 United States 4 Banyan Wood Court Unit 202 items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 0 Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: "natural", Specify: 3 Widowed 4 Divorced White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturally jujury or other traumatic event, the Medical once. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Publishing Magazine Company 12 Years Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mary Reynolds Raymond L. Gates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2071 Paperbark Road Essex, Maryland 21221 Akisha Soth (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State Hilltop Service Corp. 5/23/2011 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signatury of Funeral Service Licenses Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Stac Liver End 2 Discus disease or condition Medical resulting in death) **Examiner** TITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Day Pregnant at time of death 2 NO Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown To Be Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed' 2 No Yes 2 🕒 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 TNo HOSAN 24 filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Sther (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural Pending 1 Yes 2 No Accident Suicide Investigation Director: Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hound to the Funer completed file 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner, to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title/bf certifier 00 7063 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 701 ST 2 Int Charres SVIFE eur 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 23 Registrar

OHMH 17 Rev 7/2009

11-03679	
Dustin Higbie	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene. 2011 16285

oustin Higble		1- For State	tate of Maryland		aπment of rtificate of		Mental		eg. No.			
Physici		1. Decedent's Name (First, Midd	•					2. Date of Dea Month	ith Day Year	3. Time of Death		
Medical Exam	iner	Dustin 4a. Facility Name (if not institution		Higbie		b. City, Town, or Lo	ocation of Dea	May 16, 2	4c. County of De	0915 hrs		
		Mayfield Avenue & G				Elkridge			Howard			
Funeral Director		5. Social Security Number 220-33-5001	6. Sex 7. A	Age (In yrs. I 20	ast birthday) Yrs.	if Under 1 Year Months Days	If Under 24h Hours M	lin	rth(MM/DD/YYYY) 9. (-1991	Birthplace (State or eign Country) Maryland		
my		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location	on				10d. Inside City Limits		
aryland Ba-f show a	៦	MD Howai	rd			Сс	lumbia			1 Yes 2 XX No		
Maryla r 28a-f	Director	10e. Street and Number				10f. Zip Code	21046	1	0g. Citizen of What Co			
with the Maryland ns 23a or 28a-f sho be notified at once.		9636 Hingston	DOWNS 12. Was Decede	nt Ever in U.	.S. 13. Was	Decedent of Hispa	Specify Yes or No	United St	ates erican Indian, Black,			
death v or item	Funeral	1 XX Never Married 2 M	Armed Force			s, specify Cuban, N			White, etc.			
rs after iral", o	è	3 Widowed 4 Div	vorced If Yes, Give Year or Dates:	ompleted)		Yes 2 X No		f work done	Specify: Wh			
72 hour	eted	Elementary/Secondary (0-12)				st of working life. D			TOD. KING OF BUSINESS	3/III/dustry		
15-0036 filed within 72 hours after death with the Maryland 11 Hygiene. ed other than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at once	Completed	11	1	Wash	ing Atten		Car Was	h				
21215-00 huld be filed with Mental Hygien marked other	BeC								•			
MD 21215-0036 of 2 should be filed within 7 th and Mental Hygiene. In 27 is marked other than numatic event, the Medical	2	19a. Informant's Name/Relationship (Type, Print) Scott Higbie - Father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9636 Hingston Downs, Columbia, Marylnd 21046										
imore, MD 2 Pages I and 2 shou nent of Health and In sant: If item 27 is u or other transastic	210	20a. Method of Disposition			Place of Disposi	ion (Name of ceme	•	Date	20c. Location - City			
MOF Pages 1 net of 1 or other	ų	1 X X Burial 2 Cremation 4 Aponation 5 Other S		State	crematory or oth dowridge		ırk 05	-21-2011	Elkridge	, Maryland		
Baltimore, permit. Pages 1 an Department of Hea Important: If ites	1	21 grature of Funeral Service		2				-		al Home at		
Physician		23a. Fart I. Enter the disease, or	complications that cause	ed the death.						, MD 21075 Approximate Interval		
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease	a. Narcotic			ntoxicati	Lon			Between Onset and Death		
-		or condition resulting in death)	Due to (or as a con	sequence of	f):							
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cor	sequence of	f):							
16- =	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of	ř):							
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed ar death. reteor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit	Medical E	X UNPENDED	d. AMENDED 23	a,27,2	8a-f,pe	r me g915	5 5-25-	-11 sm				
760, cate be exe physician a	/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outc		_				23d. Date of delive	· 1		
Box 6876 The death certificat The attending phened for use as the	cian/	past 12 months?	I CIVE DITTI	at time of de		al death 3 er (Specify)	Ectopic pregr	nancy	Month	Day Year		
BO) he deatl the att	Physi	Part II. Other significant condit	known 9 Unknown	oth but mot so			en in Doct I	220 Did to	bacco use contribute t	o the cause of death?		
ires that the signed by	Š	Fatti. Other significant condit	contributing to des	atti but not re	sumg m me ar	idenying cause give	ailm raiti.			obabiy 4 🗹 Unknown		
ords, w requir	Completed							24a. Was a		autopsy findings available completion of cause of		
Recc The lavicate hapage 2	MO.							perfor 1 Yes				
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?	Hospital:	ient 2	ER/Outpatient		Death (Check		Residence 6 🗸 Oth	er: Scene		
n of Viding Physical After this funeral dir	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of In (Month, Day	jury	28b. Time of Inj				now injury occurred			
Division tal or Attendiu ts after death.	catio	Natural 5 Pend 2 Accident Invest	stigation		fd 9:00	am 1 Yes	2 X No	Unknown		hard Doute Number City		
Divi	Certification:		d not be		,	eat of ca		or Town, S Elkrids	tate May field A	tural Route Number, City ve.& Greentree		
Divis To the Hospital or 4 within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier 1 Certifying Pt	hysician: To the best of i	ny knowledg	e, death occurre	ed at the time, date	and place, an	d due to the cause	e(s) and manner as sta	ated.		
within to comp	Medical	one) 2 Medical Example 29b. Signature and title of certifie	miner: On the basis of ex and manner stated er			29c. License n		at the time, date a	29d. Date signed (M			
		The series	VI 16- 8	TA	K	O.C.M.		E	May 17, 2011			
		3. Name and address of person	·		,	00 W. Baltimoi	re Street F	Raltimore MAC	1 21223			
K j	ate	Theodore M. King, Jr.,		ar's Signatu	re .		e Street, b	oailimore, ML				
Regist		MAY 2 3 2011	A luce .	A.	bares					1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health at	nd Mental Hy	giene	16286
			T = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)	2. Date of De	Reg. No.	10200
1 4	Physicia Media		yvonne Harden	Month May	Day Year 18 201	3. Time of Death
341	Examir	ner	4a. Facility Mame (if not institution, give street and number) 4b. City, Town, or Location of Owings Mi		4c. County of Dea	More.
	Funeral Director		5. Social Security Number 214-80-3691 6. Sext 7. Age (In yrs. last birthday) 1 M 2 X F 53 Yrs. If Under 1 Year If Under 24 Months Days Hours	4 Hrs. 8. Date of Bir Min. (Month, Da	th 9. Bi	rthplace (State or Foreign ountry)
	aryland a-f show iied at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location, Wings Mills			10d. Inside City Limits 1 ☐ Yes 2 📉 No
	ith the Ma 23a or 28a st be notif	Funeral Director	10e. Street and Number 14F Deer Lodge Court 21(17		10g. Citizen of What C	ountry?
	death w	Fune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, If	n? (Specify Yes or No- Puerto Rican, etc.)		erican Indian,
9000	ours after tural", or al Exami	ted by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.		Specify:	Black
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 24 Cavs 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) Nurses ASSISTA		16b. Kind of Business St. Agnes	
	uld be filed w Mental Hyg narked othe natic event,	To Be	17. Father's Name (First, Middle, Last) 18. Mother's	's Name (First, Middle,		
Maryland	and 2 should Health and Mi tem 27 is mar ither traumati	1 5	19a. Inform 's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of 32 Meriam Cou	or Rural Route Numbe	er, City or Town, State, Z	
Baltimore,	0 0 = =		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 05 25 2011	20c. Location - City o	
Balti	permit. Page Department Important: any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8728 Liberty	yayann C.		Hora Services
}	Pnysician/	9	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line. Immediate Cause Final			Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):			unkuu-
, p	ited d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause Erter Unerly ly Cause (Disease or iinjury			
9	eath certificate be executed attending physician and for use as the burial-transit					
876	certificate anding phy use as the	Med	IF FEMALE:			
Box 687	e de de	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23d. Date of de Month	elivery Day Year
	v requires that the dees been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute t	o the cause of death?
cord	The law requires ate has been sign page 2 should be	Completed	hypertersion.	24a. Was	psy prior to	utopsy findings available completion of cause of
al Re		Be Cor		1 🗆 Yes	ormed? death? 2 No 1 Ye	es 2 🗆 No
r Vit	Physician; this certific ral director,	ပ	1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nurs		dence_6	cify)
Division of Vital Records,	Attending F er death. ector: After by the funera	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		now injury occurred	
Divisi	al or Att s after da al Directo ed in by t	I Certi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Number or Ru vn, State)	ural Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death to the Funeral Director. After this certific completed filled in by the funeral director,	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and plated the control of the death occured at the time, date and plated the control of the death occurred the death occurr	irred at the time, date a	and place, and due to the	cause(s) and manner stated.
	To the within To the Comple		29b. Signature and title of Scriffic (29c. License number D 00707)	98	29d. Date signed (Moni	th, Day, Year)
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Efi Hessous , 1/722 Persters farm Ld	Reustentien	- MO	21136
	Star Registra		31. Nage ve 2/13t/201 (ear) Source 32. Registrar's Signature			

11-03747 Tyler Lee Hickman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend # 1500 of Petry End (2) 1500

		1- For State 1- For State Certificate of Death Reg. No.	1628
Physici Medical Exami		Month Day Year	ime of Death
Medical Exam	IIIGI	Tyler Lee Hickman May 18, 2011 Year 2 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	2125 hrs
		Harford Memorial Hospital Havre de Grace Harford	
Funeral Director			ce (State or Maryland
Aud		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d.	. Inside City Limits
und show	5	Maryland Harford Aberdeen 1	Yes 2 No
Maryland 28a-f show	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
ith the Maryland 23a or 28a-f sho notified at once	į	1942 Bennett Road 21001 USA	
r death wi	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American In White, etc.	
11215-0036 Id be filed within 72 hours after fental Hygiene. narked other than "natural", event, the Medical Examiner	à	3 Widowed 4 Divorced of Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done) 16b. Kind of Business/Industr	
2 hour	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industration (Give kind of work done during most of working life. DO NOT use retired)	ry
036 ithin 7 ithin 7 fedica	흩	8 Student Student	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medical			
d be fi fental	Be	Donald Hickman, III 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number City of Town State Zin C	
4 8 E E 8	٩	19a. Informant's Name/Relationship (Type, Print) Angela Weber (mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. 1942 Bennett Road, Aberdeen, MD 21001	Code)
	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town,	, State
MOF Pages Sent of ant: If		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: R.A. Ferris & Company 5/24/2011 West Chester	. 107
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Strice Licensee 22. Name and Address of Facility Tarring—Cargo Funeral Ho	
		Aberdeen, Maryland 21001	one, P.A.
Physician /Medical			proximate Interval tween Onset and
xaminer	İ	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Death
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	ner	if any leading to immediate	
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
ecuted and transi	<u>e</u>	d	
fox 68760, leath certificate be executed a strending physician and for use as the burial - transit	Medical	UNPENDED	
376(ficate g phys s the b	We !	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Month Day	V
x 68 h certi tendin use a	ician	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	Year
BO re deat the at	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	
ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be executed eath. for: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transi	Ð.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the ca	
Sen sig	E E	24a. Was an 24b. Were autopsy f	
COC Ilaw r has b	Completed	autopsy prior to complet performed? death?	
Division of Vital Records, tal or Attending Physician: The law requires after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the control of the con		1 ✓ Yes 2 No 1 ✓ Yes	2 No
# // // // // // // // // // // // // //	mĭΙ	examiner? Hospital: 4 Inpution: 2 EP/Outpution: 3 DOA Other, National Lands	
ing Phy	입	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
ion tendir eath. for: A	Certification:	1 Natural 5 Pending Pending Investigation Nay 18, 2011 Pending Investigation Natural N	ent and
Divisipital or At ours after d icral Direct filled in by	ij	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Rough State)	ute Number, City
Spital bours hours	3	4 Homicide Solerimied (Specify) Field 2427 Old Robinhood Road, Havre de Gra	ice, MD
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,	id	Check only one) 2 Wedical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.	e(s)
£ ≱ £ 8	N S	29b. Signature and title of certifier 29d. Date signed (Month, Da)	y, Year)
		Cielo Caller Jeef O.C.M.E. May 19, 2011	
7		30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
Sta	afe S		
Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles Andrew Johnson 2 :35PM MAY Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospi tal of Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Hours 08-12-1929 Country) 223-32-6499 Director 81 Usual Residence of Decedent 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD Baltimore 1 X Yes 2 No 10e. Street and Number 5 or than "natural", or items 23a or the Medical Examiner must be 10g. Citizen of What Country? Funeral 1217 Ashburton St. 21215 U.S. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give þ 1 Never Married 2 X Married Black, White, etc. 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify: Year or Dates Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Welder Driver Welding / Driving Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Charles A. Johnson Mary Cobbs other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Dorothy L. Johnson / Wife 1217 Ashburton St. 21216 Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Baltimore City, MD Baltimore Cemetery 5/23/2016 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility Tri-State Funeral Services 814 Upshur St., NW / Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ bilateral cerebellar disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner hydro cephalus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Quality for as a consequence of sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à peripheral vascular disease, Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed hyperlipidemia hypertension, , BPH. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s osteomy elith's performed 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗆 Yes , 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA this 24 hours after death.

Funeral Director: After this leted filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. соmpleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certifier 29c. License number M.D.

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, M.D

32. Registrar's Signature

Surajit Saha

31. Date filed (Month, Day, Year)

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Sinai

Hospital of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 05 Bernadine Anna Keller 2011 06:58 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Care Center Baltimore lowson Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 X F Months Days Hours Min 05/08/1917^{ar} Director 94 219-16-8450 Usual Residence of Deceden 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and the file 23a or 28a-f sho and the file 27 is marked other than "natural", or items 23a or 28a-f sho ury or orther traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Tes 2 X No Harford White Hall 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2721 Troyer Road 21161 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ James С. Merz Amelia Grill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan K. Bena, Daughter 2721 Troyer Road, White Hall, MD 21161 Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State □ Burial 2 □ Cremation 3 □ Removal from State 05/25/2011 Most Holy Redeemer Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc. 22. Name and Address of Facility llesandra 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical Due to (as a consequence of): **Examiner** Sequentially list conditions, if any less cause. Enter Underlying Cause (Disease or iinjury Examine uence of ng physician and as the burial-transit と、か rclc that initiated events or Attending Physician: The law requires that the death certificate be execu resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Day 1 Yes 2 Unknown ate has been signed by the page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes 24a. Was an 24b. Were autopsy findings available certificate has autopsy performed? Yes 2 prior to completion of cause of death?

1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 🕅 No Certificate: 28b. Time of 28d. Describe how injury occurred Injury A M 1 Natural 2 Accident 5 Pending MAY 13 2x11 Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ASSIRA living within 24 hours a To the Funeral I completed filled the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occu red at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year)

State Registrar

Date filed (Month, Day, Year,

MAY 23 2011

610

nd address of person who completed cause of death (Item 23a) (Type, Print) HALLES

W

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Alicia Physician/ King Month Day Christine 2:20 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SINHI HOSPITAL OF BALTMORE BALTIMORECITY Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 2 F Days Hours 215-92-196 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland notified at Director 1 Yes 2 140 mD Man 10e. Street and Number Of, Zip Code 10g. Citizen of What Country? ms 23a or Funeral 21207 1133 New field USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black White etc. 1 Never Married 2 Married þ Yes 2 LAM Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Asst 2yes Department of Health and Mental Hygie Important: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Strawther Page 1 and 2 should be nent of Health and Ments obie ina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kine (mother) 1133 Newfield ed GruyNN Oak, mg. 21207 20a. Method of Dispositio 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 6 1 Burial 2 Termation 3 Removal from State 121 Baltimore, MD. Injury 4 ☐ Donation 5 ☐ Other (Specify) Vaugno C. Greene Final Se 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Van Battomp, 21229 ito watil Pike 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final arythemias Physician/ Cardia c disease or condition resulting in death) 1 DAY Medical Due to (or as a consequence of) Examiner asystole 1 DAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Hypertension 540 physician and the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last mellitus insulin dependent 5 445 Physician/Medical Diabetes Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 1 Yes 2 No 9 Unknown Division of Vital Records, P.O. been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by gluseal duewe 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 s Hospital or Attending Physician: The law autopsy 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Hospital 2 🗌 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 Yes 2 No s after decral Director; After hy the fire iniury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral D

completed filled i Medical Yertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D30494 5-16-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21228 716 maidenchoice lane DESTI MO

Registrar

31. Date filed (Month, Day, Year)
NAY 2 3 2011

NSHN

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 9:15 AM Theresa M. Kessler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Battimore Wright If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F 88 Months Days Hours Min. 0373771923 Director 215-16-0758 Maryland Usual Residence of Decedent other than "natural", or items 23a or 28a-f show rent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 XYes 2 No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5046 Wright Avenue 21205 United States filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married timore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic eve once. ည August Kordek Josephine Myszkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7407 Alvah Avenue Apt. G Baltimore, Maryland 21222 Dawn Evans - Granddaughter 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 \square Cremation 3 \square Removal from State cemetery, crematory or other place) Holly Hill Cemetery 05/24/2011 Middle River, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 130 an 1. Enter the disea shock, or heart failure. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ OPD 18ars disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) g physician and is the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed C KDCause (Disease or in that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: signed by the attendin d be detached for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DJD, CHF 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy page death? 1 ☐ Yes 2 ☐ No Yes 2 XNo funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{X}\) Residence 6 \(\sum \) Other (Specify) 1 ☐ Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 3 🗷 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

MD

Eastern

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Holden

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Henry 201 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death andallstown Northwest If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Ye October 18, 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days Hours Maryland 218 03 0096 90 Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Howard Woodstock 1 ☐ Yes 2 K No Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 10800 Davis Avenue 21163 U.S.A. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1. Marital Status Armed Forces?

1 Yes 2 If Yes, Give 1 Never Married 2 Married ₩IJ 1 Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Research and Development Machinist Koppers Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Meyers Grace Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry N. Meyers, Jr. 932 Shirley Manor Road Reisterstown, Maryland 21136 son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖺 Burial 2 🗌 Cremation 3 🗌 Removal from State Holy Cross Cemetery 4 Donation 5 Other (Specify) May 20, 2011 Baltimore, Maryland 22. Name and Address of Facilit McCully Polyniak Funeral Home P.A. of Suneral Service Licensee 237 East Patapsco Avenue Baltimore, Maryland 21225 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a co Cause (Disease or iinjury that initiated events resulting in death) Last 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
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Medical Examiner Division of Vital Records, P.O. Box 68760

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within 72 hours after

Baltimore, Maryland 21215-0036

Examiner

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IF FEMALE:

27. Manner of Death

X Natural

29a Certifier

Accident

Suicide

☐ Homicide

29b. Signature and title of certifier

5 Pending

Investigation

determined

6 Could not be

To the Hospital or Attending Physician: The law requires within 24 hours af

To the Funeral Di

completed filled ir

State

Registrar DHMH 17 Rev 7/2009

Jonathan 32. Registrar's Signature 31. Date filed (Month, Day, Year)

28a. Date of injury (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d, Date signed (Month, Day, Year)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

City or Town, State)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Old Court

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28c. Injury at

ORIGINAL

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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Hygi dother the I		17. Father's Name	First, Middle, La	st)			18.Mothe	er's Name (F	irst, Middle, Mai	iden Surname)	•		
121 Id be i Aental	8	19a. Informant's Na	me/Pelationship	May Print De au	To \ 110	h Mailing Addres	ss (Street and Nu	LEN C	al Pouto Numbo	or, City or Town, State	7 Zin Codo)		
Baltimore, MD 21215-0036 pemit. Pan 2 a nat 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	H	D. Fres	d Tim	(Type, Print Pare	475)	387	wonha	11 1.	huta		.29687		
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Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page		29a Certifier	Certifying Physi	clan: To the best of m		ath occurred at th	ne time, date and pl				ed.		
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To the Hospital or Attending Physician: within 24 hours after death.	After this certi funeral directo	ate: To Be	examiner? 1 Yes 2 2 27. Manner of Death 1 Natural	No 5 Pending	28a. Date of inju (Month, Da	ury	ER/Outpatier 28b. Time of injury		Othe 28c. Injury work?	r: 4 Nursing	Home 5 Res			Specify)	
DIVISIO vital or Attendurs after deat	ral Director: lled in by the	al Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investigation 6 Could not determined	be 28e. Place of Inj building, et	c. (Specify	·)	eet, facto	ry, office		28f. Location City or To	wn, Star	te)		ite Number,
To the Hosp within 24 ho	To the Fune completed fi	Medical	(Check 2	☐ Medical Exam ☐ Certifying Nu	ysician: To the best of inher: On the basis of e ree Practioner: To the	examination	and/or inves	tigation, in death occ	n my opinio	n, death occurred time, date and p	l at the time, date	and place the cause	ce, and due to	the cause(ser as stated	l
			0.71		completed cause of c				()00	6843 ,MD 2	9 0785		5, 20,	11_	
F	Sta Registra		Ziba Sh 31. Date filed (Mont	h, Day, Year)	001 Hosp 32. Registr	ar's Sonat	ture	J Cne	verl	У, – <u>–</u>					

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Allan Year Nutter Medical May 846HR 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign MD Country) 1 ★ M 2 □ F Days Hours 216-42-6758 Min. Nov.3, 1945**Director** 65 Yrs. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 21218 10g. Citizen of What Country?
USA Funeral 2201 Cecil Ave. permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 If Yes, Give X
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify:Black Completed 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Environmental Services 10th Johns Hopkins Hosp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Eugene Green Dorothy Nutter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21239 6401 Loch Raven Blvd. Apt. 302 Balto, MD Denise C.Williams(daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Voodlawn May 23,2011 Cem Baltimore,Md . Signat of Funeral Service Liver ²² Name and Address of Facility Calvin B. Scruggs Funeral home 1412 E. Preston St. Balto, Md. Preston St. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Coronary artern disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Type Diabet 1995 Sequentially list conditions, Examiner if any, leading to introducts cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for se a consequence of: attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 2 No signed by the 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by hypertension Completed 1 X Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after deatn.

To the Funeral Director: After this certificate has I performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 10 1 🗆 Yes 2 🔁 No Other: 1 Inpatient 2 KER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 | 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 118/2011 D47546 eaus

Registrar
DHMH 17 Rev 7/2009

State

Falls Road

10753

32. Registrar's Signatu

Suit 325

Lutherville,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.O

S. Peairs

Kimberly

31. Date filed (Month, Day, Year)

MAY 23 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MAY 13 2011 ESTELLE O. PAPPAS 10:33 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death TATE HOSPICE HOUSE LINTHICUM ANNE ARUNDEL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XX CountMD Months Days Hours Min JUNE 16 84, 1945 Director 65 215.46.9178 Usual Residence of Decedent 28a-f shov ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director ANNE ARUNDEL GLEN BURNIE 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6556 PAMPANO DR. 21061 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Examiner Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. ō Black, White, etc. þ 1 Never Married 2 Married Yes Yes 2 XXNo Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify. "natural", Completed 3 Divorced 4 Divorced Specify: WHITE Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) TAX PREPARATION CREDIT UNION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F is marked o permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic e CHARLES S. OBERLANDER DOROTHY E. REINISCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL PAPPAS HUSBAND 6556 PAMPANO DR. GLEN BURNIE, MD 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 💢 cremation 3 🗆 Removal from State BAYVIEW CREMATORY, INC 4 ☐ Donation 5 ☐ Other (Specify) 5.17.2011 BALTIMORE, MD 21. Sign v re di Funeral Service Lice 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. moon CRECORY FIN M01148 426 CRAIN HWY SW CLEN BURNIE, MD 21061 Part 1. Enter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ 1an disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, thany leading to immedicause. Enter Underlying Due to for se's consecutance of Exami requires that the death certificate be executed Cause (Disease or iinjury that initiated events sician and burial-tran resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 1 Yes 2 XXNo Pregnant at time of death 5 Other (specify) Year 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed XX No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: The law page 2 s autopsy perform**X** Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 Tes 2 **XX**No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 XXVatural 5 Pending n 24 hours after death.

The Funeral Director: Af plate in by the funeral in the 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

within 2

State Registrar 29a. Certifier

only one) 29b. Signature and title of certifier

YIDHISH MARKAM, MD 31. Date filed (Month, Day,

23 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

305 HOSPITAL DR. GLEN BURNIE, MD 21061

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year) MAY 16, 2011

29c. License number

D39505

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 1630 Allen ravsons 7011 LbnoC Non /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2 HOMESTEAD DRIVE APT. OWINGS MILLS BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 60 218-54-3890 Director 06/03/1950 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐Yes 2√ No Director BALTIMORE OWINGS MILLS MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or 7 must be n 21117 IISA 2 HOMESTEAD DRIVE APT. 2A Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE Completed by 3 ☐ Widowed 4 X Divorced ih and Mental Hygiene. 7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) USED CARS USED CAR DEALER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PARSONS RUTH BALLOW NATHAN H ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is other tra 17 RUDDINGTON CT. REISTERSTOWN, MD 21136 RICHARD PARSONS/SON 20b. Place of Disposition (Name of cemetery, crematory or other place)
BETH JACOB
ANSHE VESHEAR 20c. Location - City or Town, State 20a. Method of Disposition <u>i</u> = io 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once, 05/19/2011 | ROSEDALE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of Examiner Covavan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician attending p IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 TYes 2 🔼 No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 : 1∐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 52 Residence 6 Other (Specify) ျှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral Completely filled it 1 🚣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JOF Zileell MD 16, 2011 U37573 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Battimore MO ていてゅり Placell MP 2835 Ave 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 26, per verb, g915 5-26-11 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death West Friendship Howard Angels Touch Assisted Living 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)
 NV **Funeral** Hours (Month, Day, Year) 091–18–5755 90 NY **Director** 15 1020 Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Walden NY Orange 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12586 USA 37 Wileman Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", If Yes, Give Year or Dates Specify: white Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) clerical legal secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eugene Sullivan Ruth Neville 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4106 Westview Rd., Baltimore, MD 21218 Karyn Renneberg (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 K Burial 2 ☐ Cremation 3 K Removal from State New Prospect Cemetery 5-23-2011 4 ☐ Donation 5 ☐ Other (Specify) Pine Bush, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Dav 5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To the Hospital or Attending Physician: The law requires that within 24 hours after death.

To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify Living ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 2 🗌 No Accident
Suicide
Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. 6ignarure and title of cen 30 Name and address of person who se of death (Item 23a) (Type.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

23

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene. 16299 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 82304 M GEORGE V. SHAPARD 2 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8. Date of Birth
(Month, Day, Year) BALTIMORE WASHINGTON MEDICAL CENTER GLEN BURNIE ANNE ARUNDEL Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral XX** M 2 \square F Days Hours Min. WASHINGTON D.C. Yrs Director 217.42.0511 66 Usual Residence of Decedent 28a-f show 10a. State the Maryland notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2XX No ANNE ARUNDEL GLEN BURNIE 10e Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral with 1 293 SCOTTS GLEN 21061 Page 1 and 2 should be filed within 72 hours after death a ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner muly or other traumatic event, the Medical Examiner muly or other traumatic event, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 XXNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 Divorced Specify Completed WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MECHANIC **USPS** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MALCOLM SHAPARD **ELIZABETH CHARLTON** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important; If item 27 any injury or other tr GEORGE A. SHAPARD SON 25359 DEPU LANDING WAY GREENSBORO. MD 21639 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 XXCremation 3 Removal from State cemetery, crematory or other place) **BAYVIEW CREMATORY INC** 4 Donation 5 Other (Specify) 5.30.2011 BALTIMORE_MD of Funeral Service Liv 22. Name and Address of Facility
FINK FUNERAL HOME, P.A.
426 CRAIN HWY SW GLEN BURNIE, MD 21061 CRECORY M01148 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. $\$ 23a, Part 1, Enter the dispase Approximate shock, or heart failure. Lis Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underhin Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami burial-transi and Due to (or as a consequence of): attending physician I for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe After this certificate Yes To the Hospital or Attending Physician: 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) . Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 No Accident Investigation 24 hours after deatl Funeral Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier 1 🔀 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Naise Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check within 2 To the I only one 29b. Signature ar 29d. Date signed (Month, Day, Year)

State Registrar

OV

Name and address of person who completed

31. Date filed (Month, Day, Year)
NAY 2 3 2011

cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	f Marylan	nd / Depa <i>Cer</i>	artment of H	Health a Death	and Mental H	/ 11	Bandano con	163	300
	Physicia		Decedent's Name (First, Middle DONALD KENNETH S						2. Date of D		20 ′1 °1′	3. Time of 6:08	
	Medi Examir		4a. Facility Name (if not institution		ber)		4b. City, Town, or	r Location o			y of Death	0.00	M
-	Funeral		111 BUCK I NGHAM DR 5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	GLEN BUI	If Under 2	24 Hrs. 8. Date of B	irth	ARUNDE 9. Birth		r Foreian
	Director		216.34.3446 Usual Residence of Decedent	1 XX M 2 □ F	74	Yrs.	Months Days	Hours	JUNE 25	, 1936	9. Birth	MD	
	aryland a-f sho fied at	ector	10a. State 10b. County MD ANNE			y, Town or Loc	ation				1	0d. Inside City	
	h the M a or 28 be noti	E P	10e. Street and Number	ARUNDEL	GLEN	BURNIE	10f. Zip Code			10g. Citizen of	What Cour	1 \(\sum \) Yes	2 X X No
	eath wit ems 23 r must	Funeral Director	111 BUCKINHAM DR.	12. Was Deced	lent Ever in ITS	3 13 W	21061	enanic Oria	in? (Specify Yes or No	US			
98	after de I", or it xamine	ρ	1 Never Married 2 Mar 3 Nidowed 4 Divorced	ried Armed Ford	ces? 2 🗌 No	lf	Yes, specify Cubar	n, Mexican,	Puerto Rican, etc.)	Bla	ce - Americ ck, White, e		
2-00	2 hours "nature adical E	Completed	15. Decede	Year or Date nt's Education est grade completed)	es.	16a. Decede	ent's Usual Occupa	ation		Specify 16b. Kind of B	1411111		
21215-0036	within 72 hours after death with the Maryland giene. giene than "natural" or items 23a or 28a-f sho it the Medical Examiner must be notified at		Elementary/Seconday (0-12)	College (1-4	l or 5+)	life. DC	ind of work done d NOT use retired) ABORER	uring most	of working		EEL	,	
and	e filed ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, L	· ·			JIDOKEK		's Name (First, Middle				
Maryland	2 should be th and Mer ?7 is marke traumatic		MELVIN S. SHIPLEY 19a. Informant's Name/Relationsl			19b. Mailing	Address (Street a		(N S. WOOD or Rural Route Numb	er. City or Town S	State Zin C	ode)	
	tige 1 and 2 s nt of Health t: If item 27		ANNA SHIPLEY 20a. Method of Disposition		WIFE	111 B	UCK I NGHAM		N BURNIE, ME	21061			
<u> </u>	ment of ment of ant: If it	ı	1XX Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal from S Specify)	tate C6	lace of Dispos emetery, crema N HAVEN	atory or other place		Date .23.2011	20c, Location -			
Balt	permit. Page Department of Important: If any injury or once.		21. Sign of Funeral Service L			22. F1	Name and Address	s of Facility HOME , F	P.A.				
			23a. Part 1 Enter the disease, dr shock, or heart failure. List of		M0114	8 42 . Do not enter	6 CRAIN HW the mode of dying	y SW GL , such as ca	EN BURNIE Mardiac or respiratory a	ID 21061 rrest,	T	Approximate	
~ PI	h sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. 1	as a conseque	ne	Myel	in	9		4	Interval Betwee	een eath
E	Examiner	-e	Sequentially list conditions,	b.	as a conseque	ence on,						Ü	
uted	d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that Initiated events	Due to (or	as a conseque	ence of):							
ate be executed	physician and the burial-transit	al Ex	resulting in death) Last	Due to (or	as a conseque	ence of):							
oo/ou ertificate b	ng phys	Medical	IF F&MALE:	d									
Attending Physician: The law requires that the death certific	been signed by the attending should be detached for use as		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1 Live Bir 4 Pregnar	me of pregnan th 2 Fetal nt at time of de	death 3 🔲 I	Ectopic pregnancy Other (specify)			23d. Dat	e of deliver	y Day Yea	ar
at the d	d by the etachec		9 Unknown Part II. Other significant condition	9 🗌 Unknov	vn								
v requires the	n signer	<u> </u>	Taren. Strict significant condition	ns contributing to deal	in but not resul	iting in the und	derlying cause give	n in Part I.	23e. Did to	obacco use contri Yes 2 100		cause of dea	
law red	has bee	Completed							24a. Was	an 24b. V	Vere autops	sy findings ava	ailable use of
an: The	certificate ha	0 2	25. Was case referred to medical	1			26 Plac	e of Death		rmed? d	eath?		
Physici	this ceral direc	10 B	examiner? 1 ☐ Yes 2 🗶 No 27. Manner of Death	Hospital: 1 ☐ Inp	patient 2 E	R/Outpatient	3 DOA Other:	4 🗌 Nursi	ing Home 5 Resid	dence 6 🗆 Other	r (Specify)		
ending	eath. or: After the fune	Certificate:	1 XX atural 5 Pending Investigation	(Month, a	Day, Year)	injury	28c. Injury a work? M 1 🗆 Ye	at es 2□No		ow injury occurre	d		
al or Att	after d		3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	28e. Place of	Injury - At hom etc. (Specify)	ne, farm, street	, factory, office		28f. Location (S City or Tow	Street and Number on, State)	r or Rural F	oute Number,	
Hospita	within 24 hours after death. To the Funeral Director. After the completed filled in by the funeral	Medical	(Officer 2 in Medical Ex	Physician: To the best	of examination a	and/or investiga	ation in my opinion	death occur	rred at the time date a	nd place and due	to the source	e(s) and man	er stated
To the	within To the comple		only one) 3 L Certifying I	Nurse Practioner: To t	he best of my k	rnowledge, dea	th occurred at the t 29c. License n	ime, date an	d place, and due to the	e cause(s) and mar 29d. Date signed	ner as state	ed.	51 Stated.
			Name and address of source		M,D	0-1/5		9505		MAY 20,	2011		
		L	O. Name and address of person with the same and address of the same address of the same and address of the same addres	ho completed cause of 305 HOSPITAL									
	State		1. Date filed (Month, Day, Year)		stylar's Signatur		., MD 21061						

Andrew No.	6	3	0	
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			1 - State Registrar			,	Cer	tificate of	Death		Reg. I	No.	
	Physicia	n/	1. Decedent's Name (First, Middle, La	ist)					2. Date of	Dooth		3. Time of Death
A.	Medic		HARRY A			SNYDE	ER			Month MAY	18	3 2011	9:55 P M
	Examir	ner	4a. Facility Name (if no	_		r)		4b. City, Town, o		f Death		4c. County of Deat	
~	Funeral		GILCHRIS 5. Social Security Num			Age (In yrs. I	act hirthday)	TOWS O		24 Hrs 0 D-44	Dist	BALTIMO	
L	Director		217-03-0	7077	Sex. 7.	91		Months Days	Hours		97°1°9°2	9. Birti Cou	hplace (State or Foreign untry) WV
	land shov dat	ρ		0b. County		10c. Cit	y, Town or Loc	ation					10d. Inside City Limits
	Mary 28a-f otifie	irec	MD	N/A			BALTIM	ORE					1 XYes 2 No
	h the	a D	10e. Street and Numb	er		•	•	10f. Zip Code			10g.	Citizen of What Co	untry?
	th wit ms 20	Funeral Director		LSTAFF	ROAD, #20			212				USA	
	r dea or itel niner	y F.	11. Marital Status 1 Never Married	Marriad	12. Was Deceder Armed Forces	3?		Vas Decedent of H Yes, specify Cuba	ispanic Orig an, Mexican,	in? (Specify Yes or I Puerto Rican, etc.)	No-	14. Race - Amer Black, White	
Maryland 21215-0036	e filed within 72 hours after death with the Maryland stal Hygiene. 9d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by	3 ₩idowed 4		1 ♣ Yes 2 If Yes, Give Year or Dates		1	☐ Yes 2 🛣 No	Specify:			Specify:	WHITE
5-0	hour natu	Completed	(Specif	15. Decedent's E fy only highest gr	ducation	7-		ent's Usual Occup		-6	16b.	Kind of Business I	
121	within 72 giene. ner than '	mo	Elementary/Second		College (1-4 c	or 5+)	life. DC	ind of work done of NOT use retired)	during most	of working			
2	filed wit al Hygie d other event, th	BeC	9 17. Father's Name (First	et Middle Last	 		I OW	NER				APPLIAN	CES
an	ould be file d Mental marked o matic eve	욘	SAMUEL	n, wildele, Last)		S	NYDER			r's Name <i>(First, Mido</i> ESSIE	dle, Maide	n Surname)	BROOKS
ary	should and Me is mar raumati		19a. Informant's Name	e/Relationship (1	Type, Print)			a Address (Street		or Rural Route Nun	nber City	or Town State Zin	
Σ	2 ± 2 ±	١,	SAM SNYD	ER/SON), ESSEX,		21221	0000)
ore	a 0 = =		20a. Method of Dispos		Removal from Sta	20b. P	lace of Dispos	sition (Name of atory or other place	e)	Date	20c.	Location - City or 1	Town, State
altimore,	Page 1 tment of tant: If it jury or o		4 Donation 5			· AGŬ	RAS AHA	atory or other place HIM ANSH VAS SHAL	Ĕм 5	5/20/2011		BALTIMOR	E, MD
Bali	permit. Pag Department Important: any injury o		21. Signature of Funer	al Service Lice	see.		22.	Name and Addre	ss of Facility	SOL LEV			
			23a. Part 1. Enter the	disease or com	Miger	and the death				TOWN ROAD		ESVILLE,	
5	and the same		shock, or heart fa Immediate Cause (Fin	allure. List only o	one cause on each I	ine.	i. Do not enter	the mode of dyin	g, such as c	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Pmysician/ Medical		disease or condition resulting in death)		a. Que to (or a	s a consequ	ance of						Onser and Bodin
466	Examiner					s a consequ	ierice oij.						
		iner	Sequentially list condi if any, leading to imme cause. Enter Underlyii	ediate 📶	b. Due to (or a	s a consequ	ence of):						
	cuted ind transi	Examine	Cause (Disease or linje that initiated events	ury	С.								
	cian a		resulting in death) Las	t .	Due to (or a	s a consequ	ence of):						
8760	tificate be executed ng physician and as the burial-transit	Medical			d								
89	certific nding use as		IF FEMALE: 23b. Was decedent pre	egnant	23c. If yes, outcom	e of pregnar	псу					Ood Data of data	
Вох	eath ceri e attendii d for use	Physician/	in the past 12 mor	nths?	1 Live Birth 4 Pregnant	at time of d		Ectopic pregnand Other (specify)	У		_	23d. Date of deliver Month	Day Year
О. Ш	the d by the tacher	hys	g □ U⊓known		9 LJ Unknowi		_						
P.O.	requires that the de been signed by the should be detached	by	Part II. Other significa	nt conditions o	ontributing to death	but not resu	ulting in the un	derlying cause giv	en in Part I.				the cause of death?
rds	een si ould	Completed by	Tempho	e lace	HYTEN	10	rs ea	26		1	Yes 2	2 □ No 3 □ Pro	bably 4 Unknown
CO	law re has b	nple	Ulino	4 Th	out i	u fe	chlor	L			itopsy	prior to co	opsy findings available ompletion of cause of
Re	rsician: The law is certificate has t	S				- "					erformed?	death?	2 🗆 No
Ita	siciar certif recto	m	25. Was case referred to examiner? 1 Yes 2 N	· ·	Hospital:			Othe		(Check only one)			11
Division of Vital Records,	y Phy er this eral di	e: 10	27. Manner of Death	10	28a. Date of in	jury	ER/Outpatient 28b. Time of	3 L DOA 28c. Injury	4 L Nur	sing Home 5 Re 28d. Describ			Hospice
uc.	ath. r: Afte	icat	1 Natural 5	Pending Investigation	(Month, E	lay, Year)	injury	work			o now mgo	ny occurred	
/isic	r Atte ter de recto	Certificate:	3 Suicide 6	Could not be determined	e 28e. Place of Ir	njury - At hor	me, farm, stree	et, factory, office				nd Number or Rura	l Route Number,
<u>S</u>	ital or ans aft ral Dii	_			Dulluling, e	нс. (эреспу)				City or I	fown, Stat	e)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 🗀	Medical Exami	i ner : On the basis of	examination	and/or investig	ation, in my opinio	n, death occ	ace, and due to the urred at the time, dat	e and plac	e, and due to the ca	ause(s) and manner stated.
	o the		only one)	Certifying Nurs	se Practioner: To th	e best of my	knowledge, de	ath occurred at the	time, date a	and place, and due to	the cause	(s) and manner as s	tated.
	F 3 F 0				M.	0		700		7		ate signed (Month,	
			30. Name and address	of person who c	completed cause of	death (Item	23a) (Type, Pri					-11-11	
			30. Name and address	rahee	4 6701	W.Ch	acter.	50, 20	ite 4	105, Bal	Him	elle, M	1) 21204
	State Registra	e Ir	31. Date filed (Month, D	2 3 2011	32. Regist	rar's Signatu	Je fack						

11-03752		Please Type or Print in Black Indelib					egib	le.	
Joshua Shane T	Thor	npson State of Maryland / Departme	nt of	Health and					1 1630
Blaveiei	/	1- For State Certifica: Registrar 1. Decedent's Name (First, Middle,Last)	te of	Death		10 2-12 -4 0	Reg. N	7000	
Physici Medical Exam		Joshua Shane Thompson				2. Date of D Month May 19,	Day	y Year	3. Time of Death 0846 hrs
		4a. Facility Name (if not institution, give street and number) 101 Berry Court	4	b. City, Town, or Lo	cation of Deat			4c. County of De	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	day)	Chestertown	if Under 24Hr	s IR Date of	Birth/M	Queen Anne	Birthplace (State or
Director		213–17–7581 ¹⊠м ₂□F 31	Yrs.	Months Days	Hours Mir	n.		For	eign
		Usual Residence of Decedent	113.			Mar.	10,	1980	Country)Maryland
w any		10a. State 10b. County 10c. City, Town or	Locatio	on					10d. Inside City Limits
Maryland 28a-f show 1 at once.	tor	Maryland Queen Anne's		Cheste	ertown				1 XYes 2 No
he Mai or 28 iffed a	Director	101 Berry Court		10f. Zip Code 216	30		10g. C	itizen of What Co	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumantic event, the Medical Examiner must be notified at once.	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 1		Decedent of Hispar	nic Origin? (S		No-	U.S.A	erican Indian, Black,
r death	Fune	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No		s, specify Cuban, M	•	o Rican, etc.)		White, etc.	
rs after ural",	þ	Lor Dates:		Yes 2 X No s	<u> </u>	work done	Ideh	Specify:	White
72 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ring mo	st of working life, DC	O NOT use ret	tired)	TOD	. Kind of Busines	ss/industry
or than Medic	mpl	10		roofer				roofii	ng
15-C		17. Father's Name (First, Middle, Last)		. 1B.M		e (First, Middle		n Surname)	-
21215-0036 vald be filed within 7 Mental Hygiene. marked other than ic event, the Medica	To Be	Stewart L. Thompson, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Name/Relationship (Type, Print)	Mailing.	Address (Street an		m Price		City or Town Sta	ate Zin Code)
MD d 2 sho lih and n 27 is				erry Ct.				MD 21620	
or tra		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b, Place of Crematory)ispositi or othe	ion (Name of cemete er place)	егу,	Date	20c	Location - City	or Town, State
Baltimore, permit. Pages 1 as Department of He important: If ite njury or other tr		4 Donation 5 Other Specify: Resthay		Mem. Gard		24/2011		Frederio	ck, MD
Ball permit Depart Impor		2) Signature of Funeral Service Licensee		me and Address of F					
Physician	-	23a. Part I. Enter the disease, or complications there aused the death. Do not e	nter the	802 Liber mode of dying, suc	ty Rd.	L1be or respiratory a	rrest, sh	town, MI nock, or heart	Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Asphyxia							Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of): Hanging							
	Je.	if any, leading to immediate Due to (or as a consequence of):				_		-	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of):							
ecuted and transit		d							
a a ex	giç	UNPENDED AMENDED							
B76(ificate ig phys s the b	M	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth	7 Fata	I death 3 E	Ectopic pregna	2004	23	3d. Date of delive	
Box 68760, to death certificate be exthe attending physician red for use as the burial	sicia	past 12 months? 4 Pregnant at time of death 5	=	(Specify)	_ctopic pregna	incy		Month	Day Year
the dea	Physician/Medical	Part II. Other significant conditions contributing to death but not resulting in	thouse	dorbina aguas sives	in Dod I	I 220 Did	lahaaa	. usa santributa t	o the cause of death?
ords, P.O. v requires that the sbeen signed by t	2	Contributing to death but not resulting in	ure und	Jerryling cause grven	TIM Fait I.			✓ No 3 Pr	
cords,	etec					24a. Was			autopsy findings available
eco he law ate has	Completed						ormed? 2 ✔ 1	death?	
Vital Reco ysician: The law his certificate has director, page 2 s	8	25. Was case referred to medical examiner?			Death (Check		2	••	Yes 2 No
Physic Physic r this o	2	1 Yes 2 No				g Home 5		ence 6 🗸 Oth	er: Scene
Affe	Certification:	27. Manner of Death 28a. Date of Injury 28b. Tim 1 Natural 5 Pending FOUND: Day, Year) FOUND	D:			2Bd. Describe Subject fou			
Vision Atte	fical	2 Accident Investigation May 19, 2011 0720 hr 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,						and Number or R	tural Route Number, City
Divisation At the cours after description or At the course after description or At the course of the	Ser	4 Homicide determined (Specify) Single Family Hom	ne			or Town, 101 Berry Co		nestertown, MI)
Division To the Hospital or Attent within 24 hours after death To the Fuoeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check only one) 2 W Medical Examiner: On the basis of examination and/or inverse.							
To T with Com	Medical	and manner stated. 29b. Signature and title of certifier		29c. License nur		t the time, date		Date signed (Me	` ' '
		Thodow M. King JA, W.	D.	O.C.M.E	000	E		y 20, 2011	, , ,
	ŀ	30. Name and address of person who completed cause of death (Item 23a)							
		Ana Rubio MD. Assistant Medical Examiner 900 W. I	3altim	ore Street, Balt	timore, MC	21223			
Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of Ma	aryland.					ental Hy	/gien	ne 20 I		16303	2
			Registrar	- (First 14) - 1 -	-4)		Certifi	cate of l	Death			Reg. I	No. 4 0 1	herhari	1000)
	Physicia		1. Decedent's Nam		,						2. Date of Do Month		Pay 201	ear	3. Time of Death	
	Medic Examin		Jame 4a. Facility Name (if		ond Thom	nas	4b	City, Town, o	or Location		May		1		6:20 P M	_
-	- Admini				ed Living		1 40.			rstown	1		,		ington	
	Funeral		Social Security N	umber 6. S		(In yrs. last t	// Mo	Jnder 1 Year		er 24 H <i>rs</i> .	8. Date of Bi	rth av Year	9		ace (State or Foreign	_
	Director		217-30-5 Usual Residence of	404		76	Yrs.				(Month, Da Feb. 1	9,	1935	Mar	<u>yland</u>	_
	show dat	ro	10a. State	10b. County		10c. City, To	own or Location	1						10	d. Inside City Limits	_
	Mary 28a-f otifie	irec	Maryland	Washir Washir	ngton			Hager	stow	n					1 🛮 Yes 2 🗌 No	1
	within 72 hours after death with the Manyland giener then "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	10e. Street and Nun		• •		10	of. Zip Code				10g. (Citizen of Wha			
	ath wi	uner		Rosebanl	K Way	in II C	140 141 . 5	217			, N			J.S.		_
9	or ite	by F	 Marital Status Never Marri 	ied 2 Married	Armed Forces?		If Yes,	Decedent of H specify Cuba	an, Mexica	an, Puerto Ri	can, etc.)		14. Race - A Black, V	Americar White, etc		
003	urs aft ural", Il Exa	ted	3 🛛 Widowed	4 Divorced	If Yes, Give Year or Dates.		1 🗆 1	es 2 🔀 No	Specify	īy:			Specify:	Wł	nite	
15-(72 hor	Completed	(Spe	15. Decedent's E cify only highest gr		10	6a. Decedent's (Give kind o	of work done of	during mo	st of working)	16b.	Kind of Busin	ess Indu	ıstry	
12	/ithin iene. r thar the M	Con	Elementary/Seco		College (1-4 or 5-	H)		Tuse retired) eacher					ublic s	choc	5 1	
ρ	filed v al Hyg d othe	Be	17. Father's Name (eacher		her's Name (First, Middle,			CIIC) <u> </u>	-
ylaı	id be Menta arkec atic e	유	E. Dale	Thomas					1	Margie	Steve	ens				
Var	2 should th and Me 27 is mar traumati	- 1	19a. Informant's Na				9b. Mailing Ad					. ,		, ,	de)	
e,	and 2 Healtl tem 2 ther t	ŀ	Brittany 20a. Method of Disp		randdaughte		3950 E	arr Rd	l.				PA 172			_
altimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🔀 Burial 2 [Removal from State	ceme	tery, crematory	or other plac		Da		l	Location - Cit			
a <u>ti</u>	permit. P Departm Importar any injur	1		neral Service Licens		ROCK	y Hill 22. Nan			5/25/			eral Ho		TO, MD	7
<u> </u>	99788		ath	arine (). Harl	ler		S. Ma					MD 21			
			23a. Part 1. Enter the shock, or hear	ne disease, or com t failure. List only o	plications that caused to one cause on each line.	the death. Do	o not enter the	mode of dyin	g, such as				77		Approximate nterval Between	
-	Ph, sician/ Medical	1	Immediate Cause (I disease or condition resulting in death)		a Calor		TUCO	/							Onset and Death	
	Examiner		resulting in death)	ſ	Due to or as a	consequence	e of):							7		
		ner	Sequentially list con	mediate	b. Due to (or as a	consequence	e of):					_		+ '	<u> </u>	-
1	uted nd ransit	edical Examiner	cause. Enter Under Cause (Disease or i that initiated events	injury	C											
	cerrificate be executed nding physician and use as the burial-transit	<u>=</u>	resulting in death) L	ast	Due to (or as a	consequence	e of):				·					
209	cate b physic the b	edic			d									+		_
Box 68760	th certifica ttending p	٤	IF FEMALE: 23b. Was decedent p	pregnant	23c. If yes, outcome of								23d. Date of	f dolivon	,	
S S	of the	sicia	in the past 12 m	nonths?	1 Live Birth 2 4 Pregnant at t	Fetal death	ath 3 🗌 Ecto 5 🗌 Othe	pic pregnanc er (specify)	cy .				Month		ay Year	
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Division of Vital Records,	ar or y s after il Dire		4 Homicide	determined	building, etc.	(Specify)	iam, sacci, ia	story, office		201	City or Tow		nd Number or e)	nurai no	oute Number,	ļ
_ ;	To the Prospital or Attending Prystoran: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier 1	Certifying Phys	sician: To the best of m ner: On the basis of exa	y knowledge	e, death occure	d at the time,	date and	place, and d	due to the car	use(s) a	and manner as	stated.	(-)	_
4	thin 2 the F		only one) 3	□ Certifying Nurs	e Practioner: To the be	est of my know	wledge, death o	ccurred at the	time, date	e and place, a	and due to the	e cause	(s) and manner	r as state	d.	1.
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1			30. Name and addres	ss of person who c	ompleted cause of dea	th (Item 23a)	(Type, Print)	N 7	2]7	رے			1-6	,		_
10			Khalid	M. Waseer	m, M.D.	1126	Opal Ct	., Hag	gerst	own, M	1D 217	40				
1	State Registra		MAY 23 2	Day, Year)	32. Registrar's	Senature	1									
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11-03626 Christopher Ting	ıen	Please Type or Print in Black Indelible Ink. Ensure All Cop State of Maryland / Department of Health and Mental		egible.	1 10001									
omotophor ring	,0,,	1-For State Control of Peath Registrar Certificate of Death		Reg. No.	1630									
Physicia		Decedent's Name (First, Middle,Last)	2. Date of De		3. Time of Death									
Medical Exami	ner	Christopher Tingen 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De	May 14,	2011 4c. County of De	0840 hrs									
)		401 Mercy Street North East	eau	Cecil	sau i									
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24		Birth (MM/DD/YYYY) 9.	Birthplace (State or reign									
Director		170-64-9095 1X M 2 F 33 Yrs.	Min. 10/2		Country) PA									
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits									
*	_	MD Queen Anne Chestertown			1 Yes 2 X No									
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	Country?									
ith the Maryland 23a or 28a-f sho notified at once		131 Woodstock Road 21620		USA										
ath wit	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)	No- 14. Race - Am White, etc	nerican Indian, Black, c.									
fter de		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: Wh	nite									
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d with ygiene.	Ę	Banabape owner	ame (First, Middle	Landscap , Maiden Surname)	e .									
215 be file ntal H	Be	William Bernard Tingen Bonnie	Sue Jnne											
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If I Item 27 is marked other than injury or other traumatic event, the Madical	MD Queen Anne Chestertown 10g. Citizen 10g. Ci													
and 2 sealth a	-	Stacie L. Tingen / wife 131 Woodstock Road, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Chestert	town, MD 21	620 or Town State									
ages 1 nt of H		1 Burial 2 X Cremation 3 Removal from State crematory or other place)	5/18/201	1	·									
altin mit. P partme portan		4 Donation 5 Other Specify: R.T. Foard Funeral Home, 21. Signature of Funeral Service Liensee 22. Name and Address of Facility R	P.A.	Rising Su I Funeral H	un, MD									
		1259 East Main St.	Elkton.	MD 21921	Tome, r.A.									
Physician // // // // // // // // // // // // //		23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):												
		Sequentially list conditions, b												
	nine	if any, leading to immediate cause. Enter Underlying Cause. Due to (or as a consequence of): Clicence or injury the initiated c.												
ed nsit	Examiner	events resulting in death) Last Due to (or as a consequence of):												
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'60, ate be	Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv	ery									
687 certific	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic preg	gnancy	Month	Day Year									
Box e death the atter	Physician/Med	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown												
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duires en sign	ted	Congestive heart failure, emphysema	- 1 ✓ Ye		robably 4 Unknown									
Cords law requir	Completed		auto		autopsy findings available o completion of cause of									
tal Reco		25. Was case referred to medical 26.Place of Death (Chec	1 ✓ Yes	2 No 1 🗸										
Vita ysician his cer	Ď	overniner?		Residence 6 🗸 Oth	ner: Scene									
ing Ph	١	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	_	how injury occurred										
Sion Mittend death. xctor:	gtic	Natural 5 Pending Fd 5-14-11 Fd 8:30 am 1 Yes 2 x No Investigation		t took drug										
Divi	ertification:	3 Suicide 6 Could not be determined (Specify) found in dwelling		(Street and Number or I State) 401, Merc East, Md.	Rural Route Number, City									
y file	ပြု	4 Homicide Specify found in dwelling 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a												
To the within To the comple	g	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d at the time, date	and place, and due to	the cause(s)									
	Σ	29b. Signature and title of certifier 29c. License number 20 C. M. F.		29d. Date signed (M	fonth, Day, Year)									
	-	30. Name and address of person who completed cause of death (Item 23a)		May 15, 2011										
		Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltim	nore, MD 212	23										
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature												
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 12:15A ^M Louise 05 2011 Wilbon Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months (Month, Day, 12 05 1 □ M 2 🖺 F Days Hours Min. Country) 577-38-0602 **Director** 88 GA Usual Residence of Decedent Show or 28a-f shove se notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 🙀 Yes 2 🗌 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 20901 905 Loxford Terrace USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates 3X Widowed 4 □ Divorced Specify: Black Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher DC Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot Laudrick Meriwhether Hill Lillie Mae Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roderick Wilbon/Son 9039 Sligo Ck. Pkwy #1607 Silver Spring,MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or c Department of Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rock Creek Cemetery | 05/21/2011 | Washington, DC . Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011 The 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Cerebrovascular Accident disease or condition resulting in death) 1 month Medical Due to (or as a consequence of) **Examiner** Atrial Fibrillation Sequentially list conditions, Physician/Medical Examiner It any teaching to time date cause. Enter Underlying Cause (Disease or iinjury Due to for as a gone curron of signed by the attending physician and be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 2 9 Unknown page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension Completed 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? this certificate 1 🗌 Yes 1 🗌 Yes 2**X** No 2 3 No To the Hospital or Attending Physician; I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; t Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 Mainpatient 2 ER/Outpatient 3 DOA Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending injury work? 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) owner 05/17/2011 D50534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6858 Old Dominion Dr. #104 McLean, VA 22101 Thomas Masterson, MD 31. Date filed (Month, Day, Year) gutrar's Signature State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:10 Dorothy Marie Wilfong 20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Franklin osedale case. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F 93 1*07727*4*9*77 Maryland Director <u>215-09-5168</u> Usual Residence of Decedent show ms 23a or 28a-f shomust be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 Yes 2XXNo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6548 Blackhead Road 21220 USA ural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give 1 ☐ Yes 2XX No Specify: White Completed 3 ₩ Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) seamstress sewing Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ Harry Burkentine Della Lungren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 6548 Blackhead Road, Baltimore, MD 21220 Linda J. Umstead (daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Harford Memorial Gardens 5/20/2011 Aberdeen, Maryland Signature of Funeral Service Life nsee ^{22. Name and Address of Facility}Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ard disease or condition resulting in death) iac Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that in listed according to the conditions) Examiner The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ brillation 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate Pulm onary 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 201 0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Adna 9000 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 17, 2011 Year Michael Kenneth Yuhas, Sr. 1:13 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner . County of Death Carroll Carroll Hospital Center Westminster Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**火** M 2 □ F Days Hours Min 92 Months October 3, Year 918 188-01-7084 Pennsylvania **Director** Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Maryland Carroll Woodbine 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 851 Iron Rail Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Decedent ed Forces? Yes 2 No WII 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married XYes Completed by Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Steel Worker Bethlehem Steel permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, ; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Andrew Yuhas Anna Zvov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 851 Iron Rail Court Woodbine Maryland 21797 Michael K. Yuhas, Jr/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 5/21/11 Gardens of Faith Baltimore Maryland 21_eonard^dt@RockellInc. 5305 Harford Road Baltimore Maryland 21214 . Signature of Funeral Service Licensee, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the attending physician and the for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month Pregnant at time of death sate has been signed by the a page 2 should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SEPSIS PNEUMONA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed Yes 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 A No Hospital: Other: 1 🗌 Yes Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of completed filled in by the funeral 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 \square Pending 1 Yes 2 No Accident Investigation 6
Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🖃 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Registrar

only one)

MAY 23 2011

3 29b. Signature and title of certifier

1838 GREENE TREE RUAD #300 PILLESVILLE MD 21208 RICHARDSON M.P. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

29c. License number

D57722

29d. Date signed (Month, Day, Year,

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			For State	State of Mary			Health and		0.0	
	Physicia	in/	Registrar 1. Decedent's Name (First, Middle, Last Helen Yo	•	Cer	tillcate of t	Jean	2. Date of D		3. Time of Death
	Medio Examir	al	4a. Facility Name (if not institution, give			4b. City, Town, o	r Location of Deatl	May n	16, 4c. Count	2011 10:05AM y of Death
ممرر	<u>′ </u>		BonSecours Ho			Balt			N/	
t	Funeral Director		21/-/4-4228	× 17. Age (In 67.	yrs. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	10-23	irth lay, Year) - 43	9. Birthplace (State or Foreign Country)
	and show at	or	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Loc	cation				10d. Inside City Limits
	Maryla 28a-f s notified	Funeral Director	MD NA		Baltimo	_				X∑Yes 2 □ No
	ith the 23a or st be r	ral	10e. Street and Number 1331 Argyle Av	zenile		10f. Zip Code 2121	7		10g. Citizen of	What Country?
920	e filed within 72 hours after death with the Manyland tal Hygiene. ed other than "natural", or items 23a or 28a-f show ed other than "natural", or items 25a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puert	oecify Yes or No o Rican, etc.)	14. Rad Bla	ce - American Indian, ck, White, etc. Africar v: American
215-0	n 72 hour s. an "natu Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Seconday (0-12)		(Give k	ent's Usual Occup ind of work done of NOT use retired)	ation during most of wor	king	16b. Kind of E	Business Industry
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/land	ould be filed d Mental Hy marked ott matic even	To Be	17. Father's Name (First, Middle, Last) Ruben Lee	Young			18. Mother's Nar		a, Maiden Sumar earson	re)
Man	2 sho		19a. Informant's Name/Relationship (Type Darline Caldwe		19b. Mailin	g Address (Street	and Number or Ru Avenue	ral Route Numb e Balt	er, City or Town, imore,	_{State, Zip Code)} 21217 Maryland
Baltimore, Maryland 21215-0036	Page 1 and 3 ment of Healt ant: If item 2 ury or other		20a. Method of Disposition 1 X Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Place of Disposers Commetery, Crem Mt. Zio	sition (Name of natory or other place n Cem •	^{ce)} 05·	Date - 21 - 11	1	- City or Town, State lowne,MD
Balt	permit. Page 1 a Department of H Important: If ite any injury or oti		21. Signatule 1 Full rail epijo-License	ee						Home P.A. nore,MD 21217
	nysician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition	Colon	death. Do not ente					Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a co	nsequence of): dial In	farctio	n			
	nted d ansit	Examine	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to jor as a col	usedneuce of).					
	cate be executed physician and s the burial-transit	ical	that initiated events resulting in death) Last	Due to (or as a co	nsequence of);					
. Box 6876	ath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pi 1 Live Birth 2 4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregnand Other (specify)	cy			ate of delivery onth Day Year
P.O.	that the	by Ph	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the ur	nderlying cause giv	ven in Part I.	23e. Did	tobacco use con	tribute to the cause of death?
ds, l	v requires that the de sbeen signed by the should be detached	q pa	Dementia					1 🗆	Yes 2 No	3 Probably 4 🖔 Unknown
Division of Vital Records,	ician: The law req certificate has bee rector, page 2 sho	Completed						24a. Was auto perf	opsy formed?	Were autopsy findings available prior to completion of cause of death?
E	ctor, p		25. Was case referred to medical examiner?				ace of Death (Che		2 3 110	
Ž	Physic this or al dire	၉	1 ☐ Yes 2 ☐ No 27. Manner of Death	lospital: 1 Inpatient 28a. Date of injury	2 ER/Outpatien		4 ☐ Nursing F		idence 6 🗆 Oth	
o uc	Attending Physician: or death. ector: After this certific by the funeral director,	icate	1 Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	(Month, Day, Ye		28c. Injun work M 1 🗆		28d. Describe	how injury occur	red
Divisi	tal or Atteners after deatl	Il Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sp		et, factory, office			(Street and Numb wn, State)	er or Rural Route Number,
_	To the Hospital or within 24 hours afte To the Funeral Dir completed filled in	Medical	(Check 2 Medical Examir	cian: To the best of my ler: On the basis of exami	nation and/or investi	igation, in my opinio	on, death occurred	at the time, date	and place, and du	ie to the cause(s) and manner state
	To the I		29b. Signature and title of certifier	1997	100	29c. License	61555			d (Month, Day, Year)

State Registrar Douglas D.

31. Date filed (Month, Day, You MAY 2 3 201

Mayo, MD

BonSecours Emergency Department Baltimore, MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 W. Baltimore Street

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ ohi 4 Medical County of Death Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **E**xaminer nol If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Date of Discourse (Month, Day, . Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Country) Marvland 1 🛛 M 2 🗆 F 79 215-28-6001 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location the Maryland any injury or other traumatic event, the Medical Examiner must be notified at Director Arnold Anne Arundel MD 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral USA 21012 17 Roe Lane permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature!" 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 - Widowed 4 - Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Board of Education Pupil Personnel Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Elsie Eckert Gordon Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Roe Lane Arnold, MD 21012 Helen M. Anderson 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition Asbury United Methodist May 05, Church Cemetery 2011 1 X Burial 2 Cremation 3 Removal from State Arnold, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 Pronature of Funeral Syrvice Licens 23a Fart 1. Inter the disease or complications that caused shock, o heart failure. List only one cause on each line. Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mmediate Cause (Final teputoce Physician/ disease or o indition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g Unknown Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed peen erebrovascular accident 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy has performed 2 No within 24 hours after death.

To the Funeral Director: After this certificate 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\) Nursing Home 5 \(\overline{D}\) Residence 6 \(\overline{D}\) Other (Specify) 2 1 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d, Date signed (Month, Day, Year) 29b. Signature who completed cause of death (Item 23a) (Typ 30. Name and address of person e ti Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 201 Tear B:05 P Mary H. Austin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Solomons Nursing Center Calvert Solomons 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth **Funeral** 1 M 2 X F Months Hours Min. Month Day, Washington, D.C **Director** 577-38-7499 81 1929 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X☐ Yes 2 ☐ No Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 43015 Marwood Court 20650 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give White 3
▼ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Private Sector Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ruth P. Wildman James A. Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43015 Marwood Ct. Leonardtown, MD. 20650 Robert Austin/ Son other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State any injury or Trinity Mem. Gardens May 11, 2011 Waldorf, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Huntt Funeral Home MBU90|3035 Old Washington Rd. Waldorf, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ -alure disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.O. I signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably Allnknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. or Attending Physician: Division of Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2XNo ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical CErctifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

7634

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a),(Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#410 per PHY State of Maryla State State State AACO HEALTH DEPT.OMH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Physician/ Month Year 201 301 Medical 4a. Facility Name (if not institution, live street and number) 4b. City, Town, or Location of Death Baltimore Examiner 4c. County of Death)MMC Altimoli Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Hours Min July 4, 1988 1 JM 2 JF Director 398-06-0422 Wisconsin Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Stevenson Baltimore 1 Yes 2 X No o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1800 By Woods Lane 21153 USA items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White etc. 0 þ 1 X Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give filed within 72 hours after 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Divorced 4 Divorced Specify. Asian Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. University of MD College Student Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Kulwant Kaur Ahuja Dr. Sunil Kumar Ahuja and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1800 By Woods Lane, Stevenson, Maryland 21153 Dr. Sunil Kumar Ahuja- Father 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore Washington Crem. May 3, 2011 Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Fleck Funeral Home, Inc. Migh 10/234 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ cerebra disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine certificate be executed Cause (Disease or iinjury that initiated events ongonita anomal and Due to (r as a consequence of) resulting in death) Last physician Physician/Medical use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 2 No 2 should be detached 9 Unknown γ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy page certificate Yes 2 X No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 X No မ 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c, Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cortifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signat e and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 79532 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

68760

Box

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May 201° Bernice Allsup 1939 Medical 4a. Facility Name (if not Institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. **Funeral** Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🔽 F Dec 9ay, 1927 Director 219-38-8669 Maryland 83 Usual Residence of Decedent 10a. State 10b. County the Maryland aţ 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f Maryland Anne Arundel Annapolis 1 ☐ Yes 2X No 10e. Street and Number ō ms 23a or must be n 10f. Zip Code 10g. Citizen of What Country? Funeral and 2 should be filed within 72 hours after death with 172 Woods Dr. 21403 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or iten edical Examiner Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. Completed 3 Widowed 4 Divorced Specify: Year or Dates **Black** er than "natur , the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the I Housewife None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ Howard A. Brooks Deliah Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21403 Ola Brown (Daughter) 945 Old Annapolis Neck Rd. Annapolis, Md. 20a. Method of Disposition 20b. Place of Disposition Mame of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Memorial Park 5-7-11 Annapolis, Md. AT Lame Lease of Sacilic ons Mortuary, P.A. 21. Signature of Funeral Service Licenses Zav 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year detached the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has page 2 autopsy performed this certificate 2 🗌 No Yes 20 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\text{Yes} 2 No Other: ျှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After thi funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at Natural 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi-P 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (trem 233) (Type, Print) Judy Joseph-Herbert 31. Date filed (Month Pay, YOU) 5 2011 egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Charles Francis Adelman May 2011 8:13 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heritage Harbour Health Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🏋 M 2 🗆 F 578-36-3854 Days Hours 1/27/1929 **Director** Washington, DC 82 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland notified at 10c, City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 ☐ Yes 2 🏌 No Edgewater 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 902 Fortune Place 21037 **USA** Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Korea 1 ☐ Yes 2 K No Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If item 27 is marked other the amy injury or other traumatic event, the 1 and once. 12th Gardener Pan American Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frederick John Adelman, Sr. Edna Mary Blake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert F. Adelman/ Brother 902 Fortune Place, Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🗆 Burial 2 🗓 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Kalas Crematory 5/4/11 Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on, ach line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cades. Enter underlying Examiner consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year Pregnant at time of death Unknown 2 No Yes ate has been signed by the a page 2 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗀 No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Sta

DHMH 17 Rev 7/2009

Registrar

Name and

Date filed (Month, Day, Year)

address of person who comp

ted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY 2, Physician/ BARBARA M. ADELMAN 2011 5:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Annapolis Heritage Harbour Health Center Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 TYP Washington, DC Hours 72 Yrs Director 578-48-8676 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Funeral Director 1 🗆 Yes 2 ី No Anne Arundel Edgewater Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21037 902 Fortune Place 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🐧 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc "natural", or þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Completed 3 Divorced White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Seconday (0-12) College (1-4 or 5+) I Hygiene. 12th Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Marie Kathryn Hudson Stanley Morgan Coffren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. 902 Fortune Place, Edgewater, MD 21037 Robert F. Adelman/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Crownsville, MD MD Veterans Cemetery 5/6/11 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur 2973 Solomons Island Road, Edgewater, Md. 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 2 No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 100 ြု 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural iniur 5 Pendina 2 No 1 Yes Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ^{Day} 2011 Elaine Delores Brewington 5, 5:45 \mathbf{p}^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 119 Cove Point Road Calvert Lusby Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2**X** F Months Hours (Month, Pay, Year) 2/5/1<u>926</u> 85 Director 213-22-8057 MD Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Hant: If item 27 is marked other than "natural", or items 23a or 28a-f sho lury or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director MD Calvert 1 🌠 Yes 2 □ No Sunderland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 101 Sunderland Drive 20689 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Tes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Upholstery Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Edna Kay Lee Laird 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sunderland Dr., Sunderland, MD 20689 Albert Hastings/Son 101 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St.Peter's Cem. 5/14/11 Oriole, MD 21. Signature of Funeral Service Li 22. Name and Address of Facility Raymond-Wood F.H., PO Box 430 Dunkirk, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a c insequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has page 2 s autopsy this certificate 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🗓 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Spec 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 2 No Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registr

25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-03629 Wesley Eugene Barker State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. 1, Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Medical Examiner Month Wesley Eugene Barker 0855 hrs May 14, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 12307 Chalford Lane Prince George's 5. Social Security Number 6. Sex 8. Date of Birth (MM/DD/YYYY) **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. Foreign Country) DC Min Director Months Davs Hours 577-62-9788 **¼**XM 2 F 62 10/29/1948 Yrs Usual Residence of Decedent 10a, State iny 10h County 10c, City, Town or Location 10d. Inside City Limits 28a-f show MD Prince George Bowie 1 Yes XXXNo iten 27 is marked other than "natural", or items 23a or 28a-f abor traumatic event, the Medical Examiner must be notified at once. death with the Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 12307 Chalford Lane 20715 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc. 1 Never Married 2 Married XX No Yes Divorced If Yes, Give Year 3 Widowed 1 Yes ZXX No specify: White à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16h Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Printer Commercial Printing Com 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Frank W. Barker Eva L. Mencer ဥ 19a, Informant's Name/Relationship (Type, Print.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Lee Martin Daughter 26630 Meadowwoods Dr. Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Itimore, crematory or other place) 1 Burial 2 XXCremation 3 Removal from State 5/18/2011 | Glen Burnie, MD Donation 5 Other Specify: Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examines if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial - trans Physician/Medical AMENDED 23a, 27, per me, g916 6-30-11 sm X UNPENDED Box 68760, he death certificate be e IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the been signed by the hould be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, P.O. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed director, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has performed? death? certificate ✓ Yes 2 No **✓** Yes 2 No 25. Was case referred to medical To the Hospital or Attending Physician: 26.Place of Death (Check only one) Division of Vital examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗹 Other: Scene ER/Outpatient 3 DOA this 1 🗸 Yes မ 2 No J Director: After thed in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day,Yea 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural death. 5 Pending 1 Yes 2 No 2 _ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide filled in 6 Could not be in 24 hours

fo the Funeral Decompletely filled determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) O.C.M.E. May 15, 2011 30. Name and address of person who completed cause of death (Item 23a)

State Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Margarita Korell MD.

here A. Sale

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend Item 25 per med cert 6915 5/31/11 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2, Date of Death Month Physician/ 30 2່ດີປີ 1 5:00A M Millicent Carole Bowers April Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Crofton Care & Rehabilitation Center Crofton 9. Birthplace (State or Foreign Country) Pennsylvania 8. Date of Birth (Month, Day, May 10, If Under 1 Year If Under 24 Hrs. Social Security Numbe 6. Sex Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🕱 F 90 **1**920 Director 206-16-3483 Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director Anne Arundel Severna Park MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 21146 388 Steven Way within 72 hours after death . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces Black White etc 6 1 Never Married 2 Married Yes 2 🔀 No by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give "natural", Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) **Home** 12 Homemaker Be be filed \ 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 Anna Basavage William Koslowski permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic s 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Severna Park, MD 21146 388 Steven Way Lee Sparks / Son In Law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lie 495 Ritchie Hwy Cremation Direct Severna Park. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final ^{ty}hysician/ disease or condition WOUN Medical resulting in death) consequence of) Examiner Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant Other (specify) Pregnant at time of death been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 performed? Yes 2 No death? 1 Yes 2 No this certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) B B examiner? Hospital 1 Yes 2K No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Ursing Home 5 Residence 6 Other (Specify) Certificate: To Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred completed filled in by the funeral 28c. Injury at within 24 hours after death.

To the Funeral Director: After work?
1 Yes 2 No iniury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Priffying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Number Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 2011 D38958 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DU 208 Crain Highway, S.W. Glen Burnie, MD 21061 Daljeet Sidhu, M.D. 31. Date filed (Month, Day) Registrar's Signatur U5 2011 State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State Registrar		State of I	<i>l</i> arylar		epartme Certifica		Health and Death	Mental Hy		2011		5319
Physicia	n/	Decedent's Name	e (First, Middle, Li	7.1	D				Journ	2. Date of De	Reg. No	ay 🗸 Year		me of Death
Medic Examin	al	4a. Fapility Name (if	not institution, given	lanche ve street and number) (N(4b. Ci	ty, Town, or	r Location of Deat	251 2	7 40	c. Cøunty of Dea		SOT MA
Funeral		5. Social Security No	the Co. umber 6.	empl Sex	Age (In yrs.		Month	der 1 Year is Days	If Under 24 Hrs Hours Min.		eth	9. Bit	rthplace (S	tate or Foreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	11. Marital Status 1 Never Marri 3 Widowed	ied 2 Married	If Yes, Give		S.	If Yes, sp	ecify Cuba	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No to Rican, etc.)	-	14. Race - Ame Black, Whit Specify: 1.71		an,
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age 1 ar ent of He nt: If iter ry or oth				Removal from Sta	te (cemetery,	Disposition (A crematory of Park Co	r other plac		Date 11/2011		ocation - City or 1		
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The law recate has by	Completed									24a. Was auto perf 1 🗌 Yes	opsy ormed?	prior to death?		lings available in of cause of lo
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Vithir comp	2	29b. Signature and		00				9c. License	e number			ate signed (Mont		ar)
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 16320 State of Maryland / Department of Health and Mental Hygiene U for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ May 8, 2011 3:40 PM Ruth Lee Blom Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death McHenry Garrett 67 Longs Overlook Dr. . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Days Min June^{th, 1}0, Year 1927 California 567-26-0447 83 Director Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 XNo MD Garrett McHenry 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 67 Longs Overlook Dr. 21541 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give should be filed within 72 hours after 1 Tes 2 No Specify: 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Production Supervisor Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clarissa Hewett Robert Lee Ray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .0 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 8106 Foxhunt Circle, Glen Burnie, MD Coby Blom/Grandson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Country Side Crematory May 9, 2011 Davidsville, PA Newman Funeral Homes, P.A. 21. Signature of Funeral Service Lisensee 22. Name and Address of Facility P.O. Box 275, Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on, each line. se on,each line. Interval Betweer Immediate Cause (Final Onset and Death Physician/ Netastat disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant :
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No this certificate 1 Yes 2 No Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

To the Hospital or Attending

Maryland 21215-0036

Baltimore.

Box 68760

Division of Vital Records,

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

255 N. 4th St., Oakland, MD Daniel Buckingham, MD,

D64302

21550

May 9, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Day Month BEVERLY 201 BREEK May PM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** F Hours Months Days 216-36-4638 Pennsylvania Director Usual Residence of Decedent sho 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits the Medical Examiner must be notified at Director 28a-f 1 Yes 2 X No MD. Harford Jarrettsville 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 2304 Birmingham Court 21084 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 and Mental Hygiene. is marked other than "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Divorced 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Secretary Banking permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Nelson Lawrence Snyder Marie Louise Wright 19a. Informant's Name/Relationship (Type, PriftHusband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 2304 Birmingham Ct. Breen Jarrettsville, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May Date 8, 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) arroll 2011 Cremation Hampstead, Maryland Signature of Funeral Solvice Lice 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville, Maryland P.A. Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or such line. Immediate Cause (Final Onset and Death Ph_{sician/} disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** MR# M80028907 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a sequence of Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery P.O. Box Month Day Year 1 ☐ Yes 2 ★ 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2: autopsy performed? Yes 2 No death? 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \square Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral Certificate: 28b. Time of 28d. Describe how injury occurred 1 Watural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nuyse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the c 29b. Signature and title of May 16th 00 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tiao 500 C pper chesapeake prive Bel Air, MD 21014 31. Date filed (Month, Day, Year) 32. Registrar's Sig MAY 23 2011

Registrar

DOB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MAY 2011 CRAWFORD 6:50 MARY Ε P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. Cify, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S 5803 L STREET FAIRMOUNT HEIGHTS | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | // Month, Day, | FEB. | 5 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 X F MARYLAND Director Yrs 1931 579-38**-**2499 80 Usual Residence of Deceden 28a-f show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director DC WASHINGTON 1 X Yes 2 No 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral items 23a 5025 1ST STREET N.W. #4 20011 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc Yes 2 XNo "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 hours after BLACK 1 Yes 2 XNo Specify: 3 ♥ Widowed 4 □ Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) within 72 permit. Page 1 and 2 should be filed within.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE 12th BANK TELLER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည AGNES M. TURNER ELMER YOUNG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, ARNITA PRICE/DGT. 5803 L STREET FAIRMOUNT HEIGHTS, MARYLAND 20743 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗋 Cremation 3 🗔 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) HARMONY CEMETERY 5/9/2011 LANDOVER, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the dis shock, dr heart faill Immediate Cause (Final er the dis neart failu ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Pnysician/ disease or condition resulting in death) CHOLANGIO CARCINOMA OF LIVER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that inflicted exects. Examiner Due to tor as a consequence on executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Į in the past 12 months?
1 ☐ Yes 2 ☒ No 5 Other (specify) Month Day detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? by should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 X No this certificate 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🔼 No Other: 1 Inpatient 2 I Dgt. House ER/Outpatient 3 4 ☐ Nursing Home 5 ☐ Residence 6 🖾 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral 28d. Describe how injury occurred 1 🛚 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the 2 State Registrar

DHMH 17 Rev 7/2009

Medical

29a. Certifier

29b. Signature and siffe of certifie

Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TEMKETEM TSIGE M.D. 700 2nd STREET N.E. WASHINGTON, DC 20002

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

6, 2011

29c. License number

D32485

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	ase Type o						•		- 0	
	•	For State Registrar		State	of Maryla		epartme <i>ertifica</i>			d Mental H	ygiene, Reg. No.	2011	16323
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Medic	al	4a. Facility Name (if		iam Davie			4h Cid	Tours or	Location of De	May		3, 20 ⁴ 1	9:10 P M
Examin		516 Oa	akham C	_					na Park	atti	I I	County of Deat	undel
Funeral Director		5. Social Security No. 520–46–9		6. Sex 1 🔀 M 2 ☐ F	7. Age (In yrs		Month	ler 1 Year s Days	If Under 24 H Hours Mi			43 9. Bir	thplace (State or Foreign untry) Ohio
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmportant: I fire Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Marri 3 Widowed		rried Armed F	2 □ No ve	971 - 988			ispanic Origin? (in, Mexican, Pue Specify:	Specify Yes or No erto Rican, etc.)		14. Race - Ame Black, White Specify:	
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2 should the and Me 27 is mark traumation		19a. Informant's Na	me/Relations			19b. M	ailing Addre	ss (Street a cham (and Number or R	Rural Route Numb	er, City or I	70wn, State 2ii MD 2114	Code)
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permit. P Departm Importa any inju once.		21. Signature of Pur	-				Barra	and Addr		P.A. Sev	erna erna	Park Fi	uneral Home MD 21146
Physician/		Immediate Cause (t failure. List o Final	r complications that only one cause on e	caused the deach line.				_	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
Medical Examiner		disease or conditio resulting in death)	n	a. Due to	(or as a conse		can	CEY					1 year _
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State Registra		or. Date filed (MON)	AY 05	2011	Registrar's Sign	A. A	rack	,					

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	Funeral		Bradford Oaks Nur: 5. Social Security Number 6. Se		e (In yrs. last	birthday)	Clin If Under 1 Year	If Under 24	Hrs. 8. Date of Bir	lla .	nce Ge	place (State or Foreign
	Director		214-24-1814 1 Usual Residence of Decedent	X M 2 □ F 8	33	Yrs.	Months Days	Hours	Min. (Month, Da	13. 1	928 M	aryland
	ryland I-f show ied at	ctor	10a. State 10b. County		10c. City, T							0d. Inside City Limits 1 ☐ Yes 2X☐ No
	he Ma or 28a e notif	Dire	Maryland Prince Go 10e. Street and Number	eorges	Bra	<u>ndywi</u>	10f. Zip Code	<u> </u>		10g. Citizen c	of What Cou	
	is 23a	Funeral Director	16810 Croom Road				20613			USA		
10	r death or item niner n	y Fui	11. Marital Status 1 ☐ Never Married 2X☐ Married	12. Was Decedent E Armed Forces?	Air		Vas Decedent of F Yes, specify Cub	lispanic Origin an, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)		ace - Amerio lack, White,	
21215-0036	urs afte ural", c	Completed by	3 Widowed 4 Divorced	1 X Yes 2 If Yes, Give Year or Dates.	Force		☐ Yes 2X No	Specify:		Speci	ify: Whit	te
15-(72 hor n "nat Nedica	nple	15. Decedent's Ed (Specify only highest gra	de completed)		(Give I	ent's Usual Occuj kind of work done O NOT use retired	during most of	f working	16b. Kind of Prince		,
212	within giene. er tha t, the I	Col	Elementary/Seconday (0-12) 7th.	College (1-4 or 5		Paint				County		•
Maryland	e filed tal Hy ed oth eveni	To Be	17. Father's Name (First, Middle, Last)					1	s Name (First, Middle,	Maiden Surna	me)	
aryk iryk	ould b nd Mer mark martic		Roy Duvall 19a. Informant's Name/Relationship (T)	pe. Print)		19h Mailir	a Address (Street		ed Smith or Rural Route Numbe	r. City or Town	. State. Zip (Code)
	id 2 sh salth a n 27 is er trau		Myrtle Duvall/ Wi	fe					andywine,	Maryla	nd 206	513
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1XXBurial 2 ☐ Cremation 3 ☐	Removal from State	cem	netery, cren	sition (Name of natory or other pla		Date	David	sonvi	own, State 11e
altin	permit. Pa Departme Importan any injury		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service License		ILake		Gardens Name and Addre	Ma ess of Facility	y 13, 2011 Huntt Fur			
m	P S E E S		KILLIN	Bre					ton Rd. Wa	aldorf,	MD.	20601
	Physician/ Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a.	state	Car		ng, such as ca	urdiac or respiratory ar	rest,		Approximate Interval Between Onset and Death
- June	Examiner		resulting in deathy	Due to (or as a	a consequen	ice of):						
	rted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as a	consequen	ice of):			***			
	oe execu ician and burial-tra	g	that initiated events resulting in death) Last	Due to (or as a	consequen	ice of):						
120	icate by physics the	ledic		d								
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a g Unknown	2 🗌 Fetal d	eath 3	Ectopic pregnan Other (specify)	су			Date of deliv Month	ery Day Year
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of Vi	Physical this ceral dir	e: To	1 ☐ Yes 2 ♠No 27. Manner of Death	1 Inpatie	ry 28	3b. Time of	t 3 U DOA 28c. Inju	4 Nurs ryat	sing Home 5 Residence Residence Page 1			<u>) </u>
ono	ending sath. or: Afte	ficat	1 Natural 5 Pending 2 Accident Investigation		, Year)	injury	M 1 L	k?]Yes 2□N	lo			
Division of Vital Records,	lor Att after d Directo	Certificate:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injubulding, etc	ry - At home :. (Specify)	e, farm, stre	eet, factory, office		28f. Location (S City or Tov		nber or Rura	l Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	(Check 2 Medical Exami	ner: On the basis of ex	xamination ar	nd/or invest	igation, in my opin	ion, death occu	ace, and due to the ca urred at the time, date a	and place, and	due to the ca	use(s) and manner stated.
	o the	M	only one) 3 Certifying Nurs 29b. Signature and title of certifier	e Practioner: To the	best of my kr	nowledge, c	leath occurred at the 29c. Licens		nd place, and due to th	e cause(s) and 29d. Date sigr		
	->=0		► Weller 11	aures in			753	5206		MAY	9. 5	2011
6	2810		30. Name and address of person who c	ompleted cause of de		3a) (Type, F	rint) 11701 L	101095	tan Ronfe	Ft. W	DEHI COR	tm. My
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	B. 4	barles					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 8, 2011 1:40 Ethelene Elizabeth Durst 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Garrett 11015 National Pike Grantsville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 1 🗆 M 2 🕱 F Months Days Hours March 21^{Yea} 215-34-4550 Maryland 92 ′1919 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 X No Garrett Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21536 USA 11015 National Pike Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sewing Machine Operator 12 Textiles 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara Ellen Stark Chauncey Roy Broadwater 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10987 National Pike, Grantsville, MD David L. Durst/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Grantsville Cemetery May 11, 2011 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A.

Physician/ Medical Examiner

Physician/

Medical

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er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

l Hygiene.

permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other the any lajury or other traumatic event, the ones.

hours after death with the Maryland

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit phys the b cate has been sig

W. Lyn.	10	Russa	P.O. Box 275, Gr	antsville, i	MD 21536
shock, or h' art failure. L Immediate Cat's /(Final disease or con "ion resulting in death)	e, or com	a. CHRONIC Due to (or as a consequence of):	RENAL Sive Nephra		Approximate Interval Between Onset and Death
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ditions c	ontributing to death but not resulting in t	he underlying cause given in Part I.		2 Use contribute to the cause of death? 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
25. Was case referred to medic examiner?	170		26. Place of Death (Ch		2
1 Yes 2 No		Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	atient 3 DOA Other: 4 Nursing	Home 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Per 2 Accident Inve	estigation			28d. Describe how inj	ury occurred
3 Suicide 6 Co 4 Homicide det	uld not b ermined	e 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
(Check 2 Medic	al Exami	sician: To the best of my knowledge, dea iner: On the basis of examination and/or in se Practioner: To the best of my knowled	vestigation, in my opinion, death occurred	d at the time, date and pla	ce, and due to the cause(s) and manner stated
29b. Signature and title of cert	ifier		29c. License number	29d. D	Date signed (Month, Day, Year)
Paul o	Da		1+261	s ^{ref}	5/09/2011

Acres Dr Dakland MD 21550

State Registrar

69 Wolf

completed cause of death (Item 23a) (Type, Print)

Miller Do

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 16 2011 2:20 P M Physician/ Cora E. Eby Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Allegany Flintstone, MD 20012 West Flintstone Creek Road 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 6. Sex (Month, Day, Year) 1927 Social Security Number Mary Land **Funeral** 1 🗆 M 2 环 84 164-56-8162 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Importment of Health and Mental Hygiene.

Importment of Health and Mental Hygiene.

any injury or other traumatic event. 10a. State Director 1 🗆 Yes 2 🗗 No Flintstone Allegany MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U. S. A. 21530 Funeral 20012 West Flinstone Creek Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces Specify: White 1 Yes 2 No If Yes, Give 1 Never Married 2 Married Completed by Yes 2 No Specify. 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Housewife 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Martha (Eshleman) Hege မ Ira E. Hege 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20012 West Flinstone Creek Road Husband Wayne A. Eby 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Flintstone Mennonite May 21,2011 Flintstone, MD 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hafer Funeral Service, . Signature of Funeral Service Licenses 1302 National Hwy., LaVale, MD form 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirts, or heart failure. Line only one cause on second line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a cor Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗷 No 1 Yes Ves 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 No Certificate: To 28d. Describe how injury occurred 28b. Time of 28c. Injury at 28a. Date of injury 27. Mann f Death (Month, Day, Year) injury 5 Pending Natural 1 ☐ Yes 2 ☐ No Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide determined 4 Homicide within 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 [29d. Date signed (Month, Day, Year) 29b. Signature and title of Khanna M.D person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 32. Regi Istrar's Signature

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Jose Franklin 11-01266 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unk Unk State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar 2. Date of Death Time of Death Physician/ 1. Decedent's Name (First_Middle.Last) Month Day February 14, 2011 1020 hrs **Medical Examiner** Joel Wesley Franklin 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Charles Waldorf 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Months Days Hours Director Country) MD 6/11/1991 1 X M 2 F 19 213 33 6954 Usual Residence of Decedent 10c. City. Town or Location 10d Inside City Limits 10a State 10b County 1 X Yes 2 No 23a or 28a-f show MD Charles Waldorf Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygeree.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho rother traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20603 11201 Barnswallow Place #E USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 X Never Married 2 Married 2X No Yes Specify: White If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed 4 Divorced ρ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 1 Student Student 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Brigitte Cachard Richard Mark Franklin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11201 Barnswallow Pl.#E Waldorf,MD 20603 Brigitte Cachard/Mother 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 XXCremation 3 Removal from State or other Department of Important: 1 5/11/2011|Beltsville, MD Chesapeake Crem. 4 Donation 5 Other Specify. 22. Name and Address of Facility Briscoe-Tonic Funer Home 21. Signature of Funeral Service Licenses 2294 Old Washington Rd.Waldorf, MD 20601 Approximate Interval Part I. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and /Medical Death a Shotgun wound of torso Immediate Cause (Final disease xaminer Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): <u>n</u> if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical AMENDED 23a, 27, 28a-f, per me, g9177-14-11smattending physician or use as the burial -X UNPENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Month Year Live birth Fetal death 3 Ectopic pregnancy Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the be detached f the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed? ✓ Yes 2 No 1 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Natural 1 Yes 2 X No subject shot self within 24 hours after death To the Funeral Director: 2 - 14 - 11fd10:30 am 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, StateMitchel Rd. & S.B 301 La Plata, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 X Suicide Could not be (Specify) found in woods determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 뗩 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number February 15, 2011 O.C.M.E. outhall mes 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Pamela E. Southall, MD 31. Date filed (Month, Day, Year) Registrar's Signature State Registra

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 5:00 AM Elizabeth Williams Fick May 6. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lusby Calvert 1800 Striped Bass Court Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 6. Sex If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🖼 F Min. 10/26/1932 Yrs Director 252-46-8133 78 Georgia Usual Residence of Decedent 28a-f show 10b. County aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ed other than "natural", or items 23a or 28a-f s event, the Me ft al Examiner must be notified 1 Yes 2 W No Maryland| Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 1800 Striped Bass Court 20657 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian Black, White, etc. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 3 Married 2 3 No within 72 hours after Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done duning most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Contracting Officer Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Jonie Ivey Williams Ruth Melton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1800 Striped Bass Court, Lusby, Maryland 20657 Charles August Fick, Sr. / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 de Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05/07/2011 Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RauschFuneral Home, P.A. P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Sone marrow disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last for use as the burialphysician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death ate has been signed by the a page 2 should be detached a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D59061 May 6, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 110 Hospital Road, Suite 212, Prince Frederick, MD 20678

DHMH 17 Rev 7/2009

State Registrar Arati C. Patel,

31. Date filed (Month, Day, Year)

Box 68760

P.O.

of Vital Records,

Division

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** JULIA COVINGTON MAY 12:11p M 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 30380 Oak Street Princess Anne, Md. Somerset If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 F Director 219-36-7457 99 01-28-1912 Maryland Usual Residence of Decedent 10c. City Town or Location 10a State 10d. Inside City Limits 10b. County show ral", or Items 23a or 28a-f shov Examiner must be notifled at 1 ☐ Yes 2 No Director Md. Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30380 Oak Street 21853 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify Specify 3 Widowed 4 □ Divorced 'natural", Year or Dates White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) within 7 than, Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. Int: If Item 27 is marked other than 04 Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Covington Julia Covington ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Windsor 4526 Coulbourn Mill Rd. Salisbury, Md. Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of h Important: If Ite any Injury or ot 1 ■ Burial 2 Cremation 3 Removal from State St. Andrews Cemetery 05-11-2011 Princess Anne, Md. 4 Donation 5 Dother (Specify) Signaty Funeral Service Licenses 22. Name and Address of Facility HINMAN FUNERAL HOME M00295 21853 11673 Somerset Ave. Princess Anne. Md Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death iate Cause (Final **Physician** zhei OAVS se or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of): the attending physician a hed for use as the burial-Box 68760 certificate be Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) P.0. detached 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ be 2 No 1 □ Yes 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performed this certificate 1□ Yes 2/ 1 No Physician: ector, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 20 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 2 funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: or Attending (Month, Day Year) 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: the 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title or certifier 29d. Date signed (Moeth, Day, Year) 9

XIA

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed

32. Registrar's Signature

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th (Item 23a) (Type, Print)

rincess

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 05/01/201^D 7:52P М Helen Leah Grupe Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Arden Courts Potomac Montgomery Potomac Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Hours 04/15/1922 Director Nebraska 389 18 5987 89 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director Potomac MD Montgomery 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 United States 10718 Potomac Tennis Lane #33 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No 3 ★ Widowed 4 □ Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Banker Commercial Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Kisselman Leah Hert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4225 50th Street, NW Washington, DC Michael Grupe/Son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 s
Department of P
Important: If ite
any injury or ot 05/05/2011 4 Donation 5 Other (Specify) National Crematory Falls Church, VA Signature of Funeral Service Ligensee 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Years Death Immediate Cause (Final Physician Dementia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 XNo certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 24 No Other: ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Certificate: Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury within 24 hours after death.

Jo the Funeral Director: Al 1 ☐ Yes 2 ☐ No ☐ Accider☐ Sulcide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a, Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) 05/04/2011 D34590 le 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roy Fried MD #211 Bethesda, MD 20814 7758 Wisconsin Ave. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 05 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#10b, c,d,e,f per FH

State of Maryland / Department of Health and Mental Hygiene
Registrar 5/13/2011 AACO HEALTH DEPT ONH

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Month 5 DOUGLAS 20 2:08 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ANNE ARUNDEZ ANNAPOLIS ARUNDEL CENTER ANNE MEDICAL If Under 24 Hrs. 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ፟M 2 □ F 393-32-9156 75 04/10/1936 Wisconsin Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Prince 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Ceorce's 1 Yes 2 No 10e. Street and Number 16010 Excalibur Road Apt. A305 10f. Zip Code 10g. Citizen of What Country? *2*0716 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc þ 1 Never Married 2 K Married Maryland 21215-0036 If Yes, Give Year or Dates 1954–58 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiens important: If item 27 is marked other than any injury or other traumatic event, the Me Computers and College (1-4 or 5+) Elementary/Seconday (0-12) Electronics Programer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Donald J. Gage Kathryn Frye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Sharon L. Gage/Spouse 1519 Riverdale Drive, Annapolis, MD 21409 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Seremation 3 Removal from State Metro Crematory 4 Donation 5 🗌 Other (Specify) 05/03/2011 Baltimore, Maryland . Signature of Full ral Se ice Lice 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one sedies on each line. Approximate Interval Between Onset and Death HeUKS Immediate Cause (Final Physician/ HYPERCARBIC RESPIRA TORY disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or iinjury Dunito (or es a nonsequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Pregnant at time of death Day 4 ☐ Pregnant : 9 ☐ Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA funeral Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at (Month, Day, Year) injury 5 Pending Natural work 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide determined Medical 29a. Certifie 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F Çertirving Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) D6675 2011 who completed cause of death (Item 23a) (Type, Print) 14 200 Medica MD 05tack 31. Date filed (Month, 32. Redistrar's Signature State MAY 06 2011 Registrar

11-03269 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **David Francis Gormley** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day April 29, 2011 1541 hrs **Medical Examiner** David Francis Gormley 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's 12900 Block of Kendale Lane 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Davs Hours Min. Director 01/30/1930 countryNew York 81 106-22-7985 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c, City, Town or Location 1xx Yes 2 No MD Prince George's Bowie permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho limportant: or other transaft event, the Medical Examiner must be notified at once, nighty or other transaft event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12322 Kembridge Drive 20715 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 X Married 1 X Yes № 1952 1 Yes 2 X No specify: White 3 Widowed 4 Divorced If Yes, Give Year Specify: è 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Department of Navy 2 Logistics 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Francis P. Gormley Wilhemena McElvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean M. Gormley/Spouse 12322 Kembridge Drive, Bowie, MD 20715 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metro Crematory 5/2/2011 Baltimore, MD Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 Approximate Interval 23a: Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and /Medical Death a. Intra-oral Gunshot Wound Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED attending physician for use as the burial -Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) icate has been signed by the atto page 2 should be detached for u 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? ✓ Yes 2 No 1 🗸 Yes 2 No certificate the Hospital or Attending Physician: director, 26.Place of Death (Check only one) 25 Was case referred to medical Division of Vital Other Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 Yes 2 No After the funeral 28a. Date of Injury FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification Subject shot self 1 _ FOUND: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Natural 1 Yes 2 ✓ No 5 Pending 1541 hrs Apr 29, 2011 2 _ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 🗸 Suicide Could not be or Town, State) 12900 Block of Kendale Lane, Bowie, MD determined 4 (Specify) Woods Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. April 30, 2011 30. Name and address of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner Jack Titus MD. 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month) 32 Registrar's Signature

ORIGINAL

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May Lydia Lynn Gelder-Perez 2011 9:00 a M . Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 26 Matthews Lane Cecil Port Deposit 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Year) 1962 1 □ M 2 ¥ F Months Davs Hours July 24, ^{Country)} Maryland 219-82-4819 48 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits notified at 10c. City. Town or Location with the Maryland Director Maryland Cecil 1 Yes 2 No Port Deposit 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò Examiner must be 23a Funeral 26 Matthews Lane 21904 U.S.A. items ? within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. ō 1 Never Married 2X Married þ Yes 2 🔀 No Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced White Completed the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+)
Two Years Elementary/Seconday (0-12) Medical Transcriptionist Medquest of California and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fili Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည Paul Soden, Jr. Virginia Lee Oakley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Perez Port Deposit, Maryland 21904 (husband) 26 Matthews Lane, **Baltimore**, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place West Nottingham 05/11/11 Colora, Maryland 4 Donation 5 Other (Specify) emetery 21. Signature of Funeral Service Licenses Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or # a consequence of): disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last -trar Due to (or as a consequence of) nding physician a use as the burial-t Physician/Medical P.O. Box 68760 use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy atter in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) the s Unknown 9 Unknown signed by til I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 prior to completion of cause of death?

1 Yes 2 No has page 2 ate **Division of Vital** this certific 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 🔀 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After iniury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Sa 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date, signed (Month, Day, Year) 5 000443 2011

Registrar

State

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SUN. MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suite

Way

Colonial

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mayonth 5 Pay 20 Ye 21:45 PMM Richard Allen Goad Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cecil Union HOspital of Cecil County E1kton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Pyluaiski Virginia Ap#11, 26 Year) 1946 65 Director 217-46-2213 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Wlkton Cecil Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21921 71 Chesmont Lane 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or Ď 1 Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4XXDivorced Completed Year or Dates Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing 12 Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lucy Brady Cronk John Goad 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45 Vermont Avenue, Earleville, Maryland 21919 19a. Informant's Name/Relationship (Type, Print) Tammy Sonnier / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State May 9,2011 Cherry Hill Cemetery Elkton, Maryland 4 Donation 5 Other (Specify) 21. Signature Amere Service 22. Name and Address of Facility Crouch Funeral Home, P.A. 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) quence of): Due to (or as a con-Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical restes Box 68760 JE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Veal Pregnant at time of death Yes 2 No signed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Tyes 2 No page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 🗌 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\subseteq \text{Other} \) (Specify) 은 1 Nnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical ᢏ rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Me ical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

on can NA MD

JUI-OHIH HOU, MD

1 0 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

29c. License number

main St

DO 4023

Elloon Md

29d. Date signed (Month, Day, Year)

2011

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Charles R. Gill May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Yea
Sept. 15, Age (In yrs. last birthday) **Funeral** Days 1 X M 2 🗆 F Hours **Director** 578-22-3995 87 Usual Residence of Decedent 28a-f shov 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 9303B Wescott Drive 20850 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No Army 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) x , Dei ò 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1948–1951 1 ☐ Yes 2 🛛 No Specify. Completed 3 X Widowed 4 Divorced MAY 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working National Geographic life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Society 12 Printer Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of Elsie Charles S. Gill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Thomas C. Gill / Son 4008 Madison Street, Hyattsville, MD 20781 Baltimore, HARLES 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗵 Burial 2 🗆 Cremation 3 🗆 Removal from State Fort Lincoln Cemetery 5/10/2011 4 Donation 5 Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue idette Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. in farction Immediate Cause (Final Physician/ myocardia disease or condition Medical resulting in death) Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last and-trar Due to (or as a consequence of): ng physician a as the burial-t Physician/Medical that the death certificate be attending plant for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 - Fetal death in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24a. Was an has autopsy performed' Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) D36979 May 2, 2011 Rodeville, Maniland 20850

23d. Date of delivery

24b. Were autopsy findings available prior to completion of cause of death?

Month

3. Time of Death

1:10

9. Birthplace (State or Foreign

10d. Inside City Limits

1 X Yes 2 No

Unavailable

Approximate Interval Between

Onset and Death

Year

1923 Washington, DC

USA

White

14. Race - American Indian, Black, White, etc.

Specify:

A M

201

4c. County of Death

Montgomery

3

Registrar

this

within 24 hours after death.

To the Funeral Director; After of completed filled in by the funer

Hospital

Sherrill, mD 31. Date filed (Month, Day, Year) MAY U 9 2011

29b. Signature and title of certifier

1 🗌 Yes

27. Manner of Death

1 Matural

Accident

Suicide

4 Homicide

only one)

29a. Certifier

ည

Certificate:

Medical

2 No

5 Pending

Investigation

determined

6 Could not be

For State Registrar

9901 Medical Center Drive, 32. Registrar's Signature ack

28a. Date of injury

30. Name and address of person who coppleted cause of death (Item 23a) (Type, Print)

(Month, Day, Year)

1 Inpatient 2 FER/Outpatient 3 IDOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at

work?

1-03433	Please Type or Print				1 1000
tephen Spencer (1- For State Registrar	land / Department of Certificate of	of Health and Mental F of Death	Reg. No.	1 6336
Physician Ledical Examine	Stephen Spencer Groth			2. Date of Death Month Day Year May 7, 2011	3. Time of Death 0045 hrs
	4a. Facility Name (if not institution, give street and 654 Yorkshire Drive	number)	4b. City, Town, or Location of Deat Edgewood	h 4c. County of De Harford	eath
Funeral Director	5. Social Security Number 218-70-7975 6. Sex 1\(\bar{X}\) M 2	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr Months Days Hours Mi		Birthplace (State or reign Country) MD
any	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation		10d. Inside City Limits
≜	MD Harford	Edgewood			1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once	10e. Street and Number		10f. Zip Code	10g. Citizen of What C	Country?
with the sa 23a of sa 10 cm of			21040 /as Decedent of Hispanic Origin? (S		nerican Indian, Black,
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland thedrib and Mental Hygiene. Titem 27 is marked other than "natural", ur items 23a or 28a-f she r fraumatic event, the Medical Examiner must be notified at once To Re Commisched hy Elimeral Director	2 Midowed 4 Divorced II Yes (iVe	2 X No	Yes, specify Cuban, Mexican, Puert Yes 2 X No specify:	o Rican, etc.) White, etc. Specify: W	
"natural" "Examine		during	ent's Usual Occupation (Give kind of most of working life. DO NOT use re	work done 16b. Kind of Busine	
5-0036 ted within 72 hours a Hygiene. other than "natura the Medical Examir	Elementary/Secondary (0-12) College	(1-4 or 5+) Drywa	11 Worker	Constru	ction
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical To Be Corrolls				e (First, Middle, Maiden Surname)	
2121 hould be fill and Mental It is marked rite event,	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	June K ng Address (Street and Number or	err Rural Route Number, City or Town, S	tate, Zip Code)
re, MD 1 and 2 sho 1 Health and 7 item 27 is	Brittany Larson/ Daugl		2 Old Mill Rd. O	ceanview, DE 1997	
More Pages 1 ann of He	1 X Burial 2 Cremation 3 Remova	I from State crematory or o	other place)	16/2011 Rising S	
Baltimore, permit. Pages I ar Department of Hes Important: If ite injury or nither tr	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		Name and Address of Facility	The second secon	
ம் ஐத்த்த் Physician	23a. Part I. Enter the disease, or complications that	t caused the death. Do not enter	the mode of dying, such as cardiac	1 Home, PA Rising Sun, MD 21 or respiratory arrest, shock, or heart	911 Approximate Interval
Medical Examiner	faflure. List only one cause on each in.	1	with complicati		Between Onset and Death
r Z.Xaiiiiiei	h	s a consequence of):			
<u>.</u>	Sequentially list conditions,	s a consequence of):			
ed Insit	(Disease or injury that initiated events resulting in death) Last C. Due to (or a	s a consequence of):			
a tra	a	Items# 5,23a,2	7,per me,g916 6-	23-11 sm	
b. Box 68760, the death certificate be exemple by the attending physician iched for use as the burial - Physician/Medic	IF FEMALE: 23c. If ye 23b. Was decedent pregnant in the past 12 months?	s, outcome of pregnancy	etal death 3 Ectopic pregr	23d. Date of deli-	very Day Year
Box 6 e death cer the attend ed for use	1 Yes 2 No 9 Unknown 9 Un	gnant at time of death 5 (known	Other (Specify)		
P.C.		to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 No 3 F	
Division of Vital Records, La or Attending Physician: The law require and refer death at all Director: After this certificate has been signed in by the funeral director, page 2 should by artification: To Be Commisted.				autopsy prior	autopsy findings available to completion of cause of
tal Recoinner: The larce trificate he ector, page 2				performed? death 1 ✓ Yes 2 No 1 ✓	
Vital ysicians ysicians this certificator	25. Was case referred to medical examiner? 1 Yes 2 No	Inpatient 2 ER/Outpatie	26.Place of Death (Check nt 3 DOA Other, Nursi	ng Home 5 Residence 6 🗸 0	ther: Scene
ing Physi After this funeral dir	27. Manner of Death 1 X Natural 5 Panding	ate of Injury nth, Day,Year) 28b. Time o		28d. Describe how injury occurred	
Division of Bospital or Attending 24 hours after death. Funeral Director: After stely filled in by the funeral	Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	ace of Injury - At home, farm, str	1 Yes 2 No	28f. Location (Street and Number or	Rural Route Number, City
Div	3 Suicide 6 Could not be determined (Speci	(y)		or Town, State)	<u> </u>
To the Hospital within 24 hours a To the Funeral completely filled		is of examination and/or investig		d due to the cause(s) and manner as a at the time, date and place, and due to	
To with	0 7	r stated.	29c. License number	29d. Date signed (Month, Day, Year)
	anes	of days (the control	O.C.M.E.	May 7, 2011	
	30. Name and address of person who completed control Ana Rubio MD. Assistant Medica		Itimore Street, Baltimore, M	D 21223	
Stat Registra	31. Date filed (Month, Day, Year) 32.	Registrar's Signature			

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ April 25^{Day} 2011 6:30 AM Reginald A. Hammond Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7615 Lanham Lane Prince Georges Washington Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth 1 🛛 M 2 🗆 F 1 /2 9 / 3 Year) **Director** 033-50-1150 54 DC Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No MD Prince Georges Ft. Washington 9 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 20744 7615 Lanham Lane USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Mediral Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. <u>ک</u> 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Divorced 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Never Worked None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Reginald T. Hammond Mary Barbara Costley 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reginald T. Hammond/Father 7615 Lanham Lane Ft. Washington, Md 20744 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 5/10/11 Beltsville, MD <u>hesapeake</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home, Inc. Georgia Ave. NW Washington, DC 20011 cc0278 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Intellectual Disability disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed Chronic Kidney Disease Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Seizure Disorder Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Yes 2 No ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign Records, 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? page 1 Yes 2 No Yes 💥 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of ce 29c. License number D0069178 May 3, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6104 Dorothy Chang MD oldBranch Ave. Camp Springs, MD 31. Date filed (*Month, Day, Year*) **MAY 0 5 2011** State

DHMH 17 Rev 7/2009

Registrar

11-03455 Shirley I. Hill Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 16338 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Da May 8, 2011 0104 hrs **Medical Examiner** IRENE SHIRLEY HILL 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Raltimore Johns Hopkins Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** Months Hours Days Director 08/31/1954 GA 330-50-4441 56 Country) 2X F 1 M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Baltimore City Baltimore aarked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once. Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural?" or items 33s or 38. 6.1-1. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21205 USA 510 N. Kenwood Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No 1 Yes Specify: Black 4 X Divorced If Yes, Give Year 1 Yes 2 No specify: 3 Widowed 8 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Self Employed Office Products Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Jackson Be Jessie Rucker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6009 Chesworth Road, Catonsville, MD 21228 Jeffrey Hill/son 20c. Location - City or Town, State Rlace of Disposition (Name of cemetery, Date 20a, Method of Disposition ematory or other place) 1 X Burial 2 Cremation 3 Removation permit. Pages
Department of
Important: 1 05/17/11 Dickerson, MD Warren Cemetery 4 Donation 5 Other Speats 22. Name and Address of Facility Snowden Funeral Home nature of Funeral Service 246 N. Washington St, Rockville, MD 20850 my lications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Complications of alcohol abuse Immediate Cause (Final di ease Examiner or condition resulting in reath) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executated within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit events resulting in death) Last Physician/Medical AMENDED 23a, 27, per me, g915 UNPENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? Yes 2 No 1 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: DOA 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 1 X Natura 1 Yes 2 No 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be 3 Suicide or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie May 8, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Deputy Chief Medical Examiner Jack Titus MD. 8 2011 2. Registrar's Signature State Registra

11-03328

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Wesley Househol		Sta	ate of Maryland	d / Depa	rtment of	Health an				11 1000
	ل	- For State Registrar		Cer	tificate of	Death			Reg. No. 20	1 633
Physiciar Medical Examin	4	1. Decedent's Name (First, Middle Wesley A	_{e,Last)} dam Househ	nolder				2. Date of Dea Month May 2, 20	Day Year	3. Time of Death 1735 hrs
		 Facility Name (if not institution 9712 Amber Gate Cou 	· ·	er)		o. City, Town, or Damascus			4c. County of E Montgome	
Funeral	٩			Age (In yrs. Ia		If Under 1 Yea				9. Birthplace (State or
Director		214-41-0387	1 XM 2 F	17	Yrs.	Months Day		in.		Foreign Country) Maryland
b	-	Usual Residence of Decedent 10a. State 10b. County		Lio- oii						
d any	-1		gomery	1	Town or Location Gaithers					10d. Inside City Limits 1 Yes 2 No
arylan 8a-f si at onc	Director	10e. Street and Number	Bomery	<u> </u>	Jazener	10f. Zip Code		1	10g. Citizen of What	
		9712 Amberg	ate Court			20882			U.S.A	A.
th wid	Funera	11. Marital Status 1 🛣 Never Married 2 🗌 Ma	12. Was Decede			Decedent of His s, specify Cuban		Specify Yes or No to Rican, etc.)	o- 14. Race - A White, e	American Indian, Black,
r, or i			1 Yes	2 X No	1 .	res 2 No	snecify:		Specify:	White
ours af	6	15. Decedent's Education (Spec	or Dates:	ompleted)	16a. Decedent'	Usual Occupat	ion (Give kind o		16b. Kind of Busin	
n 72 h ical Ea	Сощриете	Elementary/Secondary (0-12)	College (1-4 o	or 5+)		st of working life.	DO NOT use re	etired)		_
21215-0036 Jud be filed within 7 Mental Hygiene Hygiene marked other than it event, the Medica	Ę	11th 17. Father's Name (First, Middle,	Last)	1	Sti	ident	18 Mother's Nar	ne / First Middle	High Sch	nool
215 se files at the	90	Randall Jay					Don		i	
221 hould I hould I is mar]≏	19a, Informant's Name/Relationsh	nip (Type, Print)		1		t and Number o	Rural Route Nu	mber, City or Town,	State, Zip Code) 20882
MD and 2 sho salth and 2 sho sa 27 is raumati		Randall Jay Hou 20a. Method of Disposition	seholder -		r 9712 Place of Disposit			t, Gait	thersburg,	, Maryland
Ore ges 1 a t of He t of He	ı	1 Burial 2 X Cremation	3 Removal from	State C	rematory or other	r place)				
Baltimore, permit. Pages I an Department of Hea Important: If itel injury or other tr	ŀ	4 Donation 5 Other Sp 21. Signature of Funeral Service		Me						dria, Virginia
Dem Dem	ų,	hovert L. 1	Villiam	1	1 264	FUL Kidg	e Road.	Damaso	, Funeral	Home land 20872
Physician //Medical	T	23a. Part I. Enter the disease, or of failure. List only one cause of	complications that cause on each line.	ed the death.	Do not enter the	mode of dying,	such as cardiac	or respiratory an	rest, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Contact Guns!							Death
	1	Sequentially list conditions,	b.	isequence or).					
		if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a con	sequence of):					
ted nisit	Xall	(Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):					
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	<u>.</u>	UNPENDED	amended 41	per 1	ne e915	5-26-11	vt.			
60, ate be « hysicia e buria		F FEMALE:	23c. If yes, outc						23d. Date of de	liven
687 rertifica ding p		3b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Feta	death 3	Ectopic pregi	nancy	Month	Day Year
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Functal Director: After this certificate has been signed by the attending physici completely filled in by the functal director, page 2 should be detached for use as the buring chiral Certification: To Be Completed by Dhusician Medical	Sic	1 Yes 2 No 9 Unk	1	at time of dea	5 Othe	r (Specify)				1
Division of Vital Records, P.O. B To the Bospital or Attending Physician: The law requires that the d within 24 hours after death. To the Funcral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached completely filled in by the funeral director, page 2 should be detached.		Part II. Other significant condition	ons contributing to dea	ath but not re	sulting in the un	derlying cause g	iven in Part I.	23e. Did to		te to the cause of death?
S, P luires ti	2							1 Ye		Probably 4 Unknown
Records, The law requires ficate has been sig page 2 should be								24a. Was autop		re autopsy findings available r to completion of cause of
Rec The ficate of the page	5	No. 111	· · · · · · · · · · · · · · · · · · ·					1 ✓ Yes		Yes 2 No
/ital	ום	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpat	tient 2	ER/Outpatient		of Death (Chec	ing Home 5	Residence 6 🗸	Other Scene
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the sale freath. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by Descriptors.	1	27. Manner of Death	28a. Date of In	niury	28b. Time of Inj]	y at Work?	28d. Describe	how injury occurred	
Sion Attendi death. ctor:	3	1 Natural 5 Pendi 2 Accident Invest	tigation May 2, 2011		FOUND: 1729 hrs		es 2 V No	Subject sho		
Division o spital or Attending hours after death hears Director: After filled in by the func		deterr	not be		me, farm, street,	factory, office b	uilding, etc.	or Town, S		or Rural Route Number, City
Hospin 24 hour Fruner tely fill		On Codifies	ysician: To the best of			d at the time, da	te and place, ar			
Division To the Hospital or Attended within 24 hours after death To the Funeral Director: completely filled in by the		one) 2 Medical Exam	niner:On the basis of ex and manner stated	amination an						
	E	29b Signature and title of certifier				29c. License		-	111.20	(Month, Day, Year)
		30. Name and address of person v	- Dr	/2	226)	O.C.N	vı.⊏.		May 3, 2011	
\		Russell Alexander MD.			*	/. Baltimore	Street, Balti	more, MD 21	223	
Stat		31. Date filed (Month, Day, Year)	32. Regist	ar's Signatur	e A	arke)		OCME		
Registra	1	PIRT U	U ZUHI LA	CORPERADA A	67. Sel	64 60				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month HARRIS CHRISTEEN 2011 8:45AM APRII Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S HYATTSVILLE ST. THOMAS MORE NURSING HOME If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Months (Month, Day, NORTH CAROLINA 82 238-44-9202 **Director** 20_ Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medikal Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No CAPITOL HEIGHTS PRINCE GEORGE'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20743 6801 PAINTER TERRACE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2X No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: BLACK If Yes, Give 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) PRIVATE HOUSEWIFE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည BROWN VASHTI WALTER EVANS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERRACE CAPITOL HEIGHTS, MARYLAND 20743 6801 PAINTER DORIS RILEY/DGT. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/4/2011 RIVERDALE, MARYLAND RIVERDALE CREMATORY 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failurg. List only one cause on each line. Immediate Cause (Final/ Physician/ otic CARDIOVASCI disease or condition resulting in death) ARTEMOSCIER CANA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of: If any, leading to immedicause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Day 5 Other (specify) Pregnant at time of death s been signed by the same should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Disease 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 sl autopsy performe Failure thri W Yes 2 No certificate +0 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, 1 🗆 Yes 2 🔣 No Hospital: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury Natural 5 Pending 2 🗀 No after death

Director: A

in by the fi ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aff

To the Funeral Di

completed filled in Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011

State Registrar 31. Date filed (Month, Day,) MAY 0 9 2011

ensbun

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Examir

	1 _ State	State of Marylan		tificate o		and iv	ientai i iy		00		
	Registrar 1. Decedent's Name (First, Middle, Last)		Cer	incate	Dealli		2. Date of De	Reg. N	0.2		1.634
n/	ESTHER	HALLEY					MAY	-	ð /11	Year	7:20 P M
al er		· ·			n, or Location				c. County		
	301 ROOSEVELT C				E DE GI				HARF	ORD	
	5. Social Security Number 6. Sex 1 15-78-6539	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Y Months Da	ear If Unde lys Hours	Min.	8. Date of Bir (Month, Da DEC 2	th y, Year)	931	9. Birth Cour GUY	place (State or Foreigi htry) N.N.A
	Usual Residence of Decedent						DEC. 2	.5 1	931 1	GUII	AIVA
ctor	10a. State 10b. County		y, Town or Loc								10d. Inside City Limits
<u>Dire</u>	MD HARFORD 10e. Street and Number	HA	AVRE DE	10f. Zip Co	do.			10 0			1X Yes 2 N
ra	301 ROOSEVELT COU	RT		1 ')78			109. C	itizen of V A	Vhat Cou	ntry?
-nue	11. Marital Status 12.	Was Decedent Ever in U.S.		Vas Decedent	of Hispanic Or		cify Yes or No-		14. Race	e - Ameri	can Indian,
Completed by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give		Yes, specify (Rican, etc.)			k, White,	
tea	3 X Widowed 4 Divorced	Year or Dates.				/. 			Specify:	222	
ă	15. Decedent's Educa (Specify only highest grade of	completed)	(Give k	ent's Usual Oc and of work do O NOT use reti	ne during mo:	st of workir	ng	16b.	Kind of Bu	ısiness In	dustry
3	Elementary/Seconday (0-12)	College (1-4 or 5+)	i .	SEWIFE				P	RIVA	ΓE	
lo Be					1		(First, Middle,			•	
_	HEBERT E. BIRTOBER		1			EBBEC.			ENZI		
	19a. Informant's Name/Relationship (Type, PAULA HALLEY/DGT.	Print)	1				RFIELD				
	20a. Method of Disposition	20b. F	Place of Dispos	sition (Name o			RFIELD :				own, State
	1 XBurial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State GI	emetery, crem LENWOOD	CEMET	olace) ERY	5/7/			HING'	-	
	21. Signature of Funeral Service Licensee		22	. Name and Ad	dress of Facil	ity J.	B. JENI	KINS	FUN	ERAL	HOME, INC.
	russ	b .									AND 20785
	23a. Part 1 - ter the / isease, or complicate shock, or heart filure. List only one can	ause on each line.									Approximate Interval Between
	Immedia Cause Final disease or condition resulting in death)	CANCER									Onset and Death
	Tooland and a second	Due to (or as a consequ	uence of):	PNEY	PISE	MJE	, 5176	e 1	Z		
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ		,						-	
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_	resulting in death) Last	Due to (or as a consequ	uence of):						-		
<u> </u>	d									\dashv	
Z ME	IF FEMALE: 23b. Was decedent pregnant 23c.	. If yes, outcome of pregna	incy						00-l D-t	6 +1 -15	
Completed by Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Feta 4 Pregnant at time of o		Ectopic pregi Other (specif					Moi	e of deliv	Day Year
'n	9 Unknown	9 Unknown					-				
à	Part II. Other significant conditions contrib	outing to death but not res	sulting in the u	nderlying caus	e given in Part	l.					he cause of death?
ited	1						1 📗	Yes 2	No No	3 ∐ Pro	bably 4 🗌 Unknow
ᇤ							24a. Was auto	psv	l p	Vere auto prior to co leath?	psy findings available impletion of cause of
S	25. Was case referred to medical				Die 15	11 (0)	1 Tes	ormed? 2 👿 N			2 x No
o Re	examiner? 1 Yes 2 XNo		EP/Outpoti		Other:			da	c 🗆 ou	··· (0 ·· ''	A.
9	27. Manner of Death	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c.1	njury at		ne 5 🔀 Resi 8d. Describe l				/)
9			iniurv	\	vork?	- 1					
Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(inonin, Bay, roar)	,,		☐ Yes 2 ☐	No					

The state of

Registrar

DHMH 17 Rev 7/2009

State

completed filled in by the funeral director,

Medical

29a. Certifier

(Check

ANDREW NOWAKOWSKI M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DO8096

501 SOUTH UNION AVENUE HAVRE DE GRACE, MARYLAND 21078

29d. Date signed (Month, Day, Year)
MHY 5, 20/(

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

11-03654 Donnie Neal Horton Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar		(Certifica	ate of	Death				R	eg. No	1.		
Physicia		Decedent's Name (First, Mide	die,Last)							2	Date of Dea Month		Year		3. Time of Death
Aedical Examir	er		Donnie-Nea		ard Ho						May 15, 2	011			0920 hrs
		4a. Facility Name (if not instituti 16 Hamer Drive Roa		umber)		41	b. City, Tow Elkton	vn, or Lo	ocation of	f Death		ı	c. County o Cecil	f Death	
Funeral Director		5. Social Security Number	6. Sex		yrs. last birt		If Under 1	Year Days	If Under Hours	Min.	8. Date of Bi	•		Foreigr	nplace (State or Delaware Intry)
4	H	214-31-3423 Usual Residence of Decedent	1 X M 2 F	20		Yrs.					11/10)/ 15	990		,
any	t	10a. State 10b. County	,	10c.	City, Town	or Locatio	n								10d. Inside City Limits
Maryland 28a-f show	5	Maryland Ced	ci1		E1kt	on									1 Yes 2 No
ith the Maryland 23a or 28a-f she notified at once	Director	10e. Street and Number					10f. Zip Co				1	•	tizen of Wh		
th the 23a or		16 Hamer Road			1-110	40.18/00		921	ania Oniai	in 2 / C no	sife Van as Na		Jnited		ates can Indian, Black,
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland Ith and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f she numatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 N	1 Yes	orces?		if Ye	s, specify (Cuban, I	Mexican,		cify Yes or No ican, etc.))-	White	etc.	
s after	À.		ivorced If Yes, Give Ye or Dates:		0 10		Yes 2 X				d. da.a.	Tack.	Specify: Kind of Bus	Whi	
5-0036 led within 72 hours after Hygiene. I other than "natural" the Medical Examine.		 Decedent's Education (Sp Elementary/Secondary (0-12 		ide complete 1-4 or 5+)			s Usual Oc st of workir					160.	Kind of Bus	iness/ir	austry
15-0036 filed within 72 I Hygiene. Ad other than 's, the Medical	Completed		2	,	Dr	iver	/Main	tena	ance/	/Mech	nanic	Ma	inten	ance	e Sweeping
5-00 ed wil tygien other	ភ្ញុ	17. Father's Name (First, Middle	e, Last)					18	B.Mother's	s Name (f	First, Middle,	Maide	n Surname)		
21215-0036 Juld be filed within 7 I Mental Hygiene. marked other than ic event, the Medica	Be	Donnie Madiso									hmeuss				
should not may be stice	유	19a. Informant's Name/Relation			1.0			•			ral Route Nur			ı, State,	Zip Code)
imore, MD 2 Pages 1 and 2 shoul nent of Health and N sant: If item 27 is n or other traumatic	-	Irene Horton/ 20a Method of Disposition	Mother	1:	20b. Place of				eterv.		MD 2		Location -	City or 1	Town, State
Ore		1 X Burial 2 Crematic	on 3 Removal f		cremat	ory or oth	er place)			May	19,			-	
	-	4 Donation 5 Other 5			Вау		v Ceme			2011			Bay V		ils, P.A.
Balt permit. Depart Impor	Į	Mint Annual William	0'	nes							treet,				
Physician	Ť	23a. Part i. Enter the disease, o	or complications that	caused the c	death. Do no										Approximate Interval Between Onset and
Medical	1	failure. List only one caus Immediate Cause (Final diseas	0	phone	Intox	cicat	ion a	nd	Coca	ine 1	Use				Death
:Xaiiiiiici		or condition resulting in death)	Due to (or as	a consequer	nce of):										
	P	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequer	nce of):										
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760, ficate by g physic the bur	2 I	IF FEMALE: 23b, Was decedent pregnant in		outcome of					7	-		23	3d. Date of		
Box 68760, e death certificate be executed the attending physician and red for use as the burial - trans	cian	past 12 months?	I LIVE	birth nant at time		\equiv	al death er (S <i>pecify</i>		Ectopic	pregnano	СУ		Month	D	ay Year
Box 68 e death certif the attending ed for use as	Physician	1 Yes 2 No 9 Ur	nknown 9 Unkr	iown											
∵ a s a !	절	Part II. Other significant cond	itions contributing t	to death but	not resulting	g in the ur	nderlying ca	ause giv	ven in Par	rt I.	1				the cause of death? ably 4 Unknown
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	Be	25. Was case referred to medic examiner?	Hospital:	Inpatient	2 EB/O	utpatient		Io	of Death (Home 5	Pesid	lence 6	Other	Scene
of Vijiing Physic	라	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury		Time of In		`	at Work?		8d. Describe				
on of anding Pt. ath. r. After the funeral	ē		nding fd 5	h, Day,Year) -15-1	1 fd	9:00	am 1	Ye	es 2 X	No [Jnknowi	1			
Division of Vital tal or Attending Physician. Its after death. al Director: After this certified in by the finneral directon.	fica		estigation	ce of Injury -				ffice bui	ilding, etc	c. 2	8f. Location (Street	and Number	er or Ru	ral Route Number, City
Divinital of the pital of the p	Certification:	4 Homicide det	ermined (Specify		siden						lkton,	Md.	16 Ha		
the Hoshin 24 h	Medical		Physician: To the be aminer: On the basis and manner	of examinat											
To with	æ	29b. Signature and title of certif		Juliou.			29c. L	icense	number				_		nth, Day, Year)
		Alle B	rasself de	()				D.C.M	I.E.			Ma	ay 16, 20	11	
	ļ	30. Name and address of person Melissa Brassell, MD				900 W	Baltimo	re Str	reet. Ba	altimore	e, MD 212	23			
Sta	ate	31. Date filed (Month, Day, Year		egistrar's Si					,						
Regist		MAY 23 2011	Ceneur	19. 1	4										

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AMEND TIEM#25,27perVERB/PHYS,G915,5723/2011,WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 8, Yveena Fortune Koontz 2011 6:40 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7 Weil Drive Frederick Thurmont . Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 💢 F Hours Min. Aug Month 22 ^{Yea}1924 205-16-4513 West Virginia Director 86 Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The mark of Health and Mental Hygiene. The mark if frem 23a or 28a-f sho ant. If free 27 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Frederick Frederick 1 🗆 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21704 5313 Reels Mill Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Home Care Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Will Pyles Viola Susan Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Koontz (Son) 22328 Rolling Hill Lane, Laytonsville, MD 20882 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit, Page 1 a
Department of H
Important; If ite
any injury or ot
once. cemetery, crematory or other place 1 XBurial 2 Cremation 3 Removal from State Fairmont Cemetery May 12,2011 Libertytown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, Maryland 21701 MO1612 23a. Part 1/Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) avdrow Tapatho Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, Examine rany, teading to immedia cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 T Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 No n signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown to the runeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should it 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Son's Other: 4 Nursing Home 2 10 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA (fy) Residence 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 5 Pending iniury 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d, Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick MD 21702 31. Date filed (Month, Day, Year) MAY 2 3 2011

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:00 PM Camper Kenn 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Spring er 24 Hrs. 8. Date of Birth Montgomery ilver HOSPITA Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗹 F Months Hours Min (Month, Day, Y **Director** Maryland Usual Residence of Decedent or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Page 1 and 2 should be filed within 72 hours after death with the Mary 10e. Street and Number 10g. Citizen of What Country? by Funeral 215 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces' Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 WNo Specify 3 Widowed 4 Divorced "natural", Completed Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Ned Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ses 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra roy 11e 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State ROCK CEMEtery 4 Donation 5 Other (Specify) Cambridge, 22. Name and Address of acility
Henry Funeral Home, R.A.
Sio washington Str Cambridg Signature of Funeral Service Licensee MD. 21613 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Sep Physician/ Si disease or condition resulting in death) Days Medical Due to (or as a consequence of): Examine nar Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day Pregnant at time of death 5 Other (specify) detached 1 ☐ Yes 2 ☑ 9 ☐ Unknown 9 Unknown P.O. I been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Stage Renal Division of Vital Records, 2 No 3 Probably 4 K Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of Diabetes 24a. Was an Mellitus To the Hospital or Attending Physician: The law autopsy performed? Yes 2 2 N within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 death? 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 1 Natural Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifi 29c. License numbe 29d. Date signed (Month, Day, Year) D32332 May 4, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Avenue, Suite 2-20, Silver Spring, MD 20902 Suresh K. Gupta, M.D

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

08 20

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph Richard Levine May 3, 20 Pay 2:45 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number Funeral Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Newnty) or k. 1 X M 2 □ F Months Hours Min. 71 0549994999 Director 054-32-2217 10b. County 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery Poolesville 1 Yes 2 □ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? United States Funeral 20837-2237 19601 Mosby Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 Np 963If Yes, Give Black, White, etc. White "natural", or Completed by 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ₺ Widowed 4 Divorced Specify: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Meteorologist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Julius Levine Rachel Jacobs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19601 Mosby Lane Poolesville, MD 20837 Daniel Levine-Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3🗶 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 05/05/2011 Beth Moses Cemetery West Babylon, NY Goldberg Memorial ille Pike MD 20852 21. Signature of Funeral Service Licensee M01163 Rockville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Acute Volvulus Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that initiated events y the attending physician and the driving the driving the purial of the driving o resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificat, has been sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔁 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No ည Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at evin 1 X Natural 5 Pending Accident Investigation 1 Yes 2 No in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ☑ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) H67499 Christine Cash 05/03/ 2011

Registrar

State

8600 Old Georgetown Road

Bethesda, Maryland 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year

MAY 05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 20<u>11</u> Physician/ Month Theodore Joseph LeBlanc, May 8:45 a^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 7. Age (In vrs. last hirthday) If Under 1 Year I If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) D.C. 1 3 M 2 🗆 Hours Director 579-30-5351 Nov. 29, Year 1928 82 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Bethesda 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9203 Wilmett Court 20817 USA permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No 1 Never Married 2 Married þ 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Dentist Private Practice Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theodore J. LeBlanc, Sr. Katherine O'Brien 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9203 Wilmett Court, Bethesda, MD 20817 Katharina Ramsey LeBlanc/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State May 4 Donation 5 Other (Specify) 2011 Silver Spring, MD 21. Sign vure of Funeral Service Licer Prancis J. Collins Funeral Home Inc. 00 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or co mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between shock, or heart failure. List only Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ardiae Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate the conditions of the con Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the buriak transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year Yes 2 No g Unknown 9 Unknown s been signed by the should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? Yes 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, æ 26. Place of Death (Check only one) 1 Yes 2 Pro Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide 1 Yes 2 No Investigation Completed filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier D0062435 30. Name and address of person who complete ed cause of death (Item 23a) (Type, Print) molecular Dr Rockville, MD 20850 Elsayyad Dayed 10110 (Month, Day, Year)
MAY 05 2011

State Registrar

		1- For State Registrar	Ce	ertificate c	of Death		Re	g. No. 201	1 1634
Physicia	an/	1. Decedent's Name (First, Middle,Last)					2. Date of Death Month	Day Year	3. Time of Death
Medical Exami	ner	4a. Facility Name (if not institution, give str	tance Marie	Lowery	Ah City Town	or Location of Dea	May 13, 20	4c. County of Dea	1415 hrs
		14701 Harold Road	cet and number)		Silver Spri			Montgomery	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Ye			(MM/DD/YYYY) 9. B	
Director		578-46-6403 1□M	2[X] F	76 Yı	s. Months Da	ys Hours Mi	n. May	28,1934 c	ountryWA State
h		Usual Residence of Decedent 10a. State 10b. County	Iton Ci	ty, Town or Loca	ation				10d. Inside City Limits
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e, N l and 2 Health item 2		20a. Method of Disposition	20b			emetery,	Date	otte, NC 2 20c. Location - City of	r Town, State
MOFE Pages 1 nent of H ant: If i		1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:		crematory or o มา.k.l.awn	other place) Mem. Pav	rk 05	/19/2011	Rockville.	, Maryland
Baltimore, permit. Pages 1 at Department of Het Important: If ite	1	27. Signature of Funeral Service Licensee	1100	22.	Name and Addres	ss of Facility Hi	nes-Rina	ldi Funera	l Home. Inc
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Physician Medical		23a. Part I. Enter the disease, or complicat failure. List only one cause on each I	tions that caused the deat ine.Aspiration	th. Do not enter 1 of blo	the mode of dying od from	g, such as cardiac erosion	of blood	st, shock, or heart I vesse1 by	Between Onset and
Examiner		Immediate Cause Final disease a. To	orus Mandibu	ılaris					Death
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876 tificate ng phy ss the 8	_	23b. Was decedent pregnant in the	?3c. If yes, outcome of pre I ☐ Live birth		etal death 3	Ectopic pregr	nancy	23d. Date of delive Month	ry Day Year
Box 687 e death certific the attending ed for use as t	sicia	past 12 months? 1 Yes 2 ✓ No 9 Unknown	Pregnant at time of	11	Other (Specify)				
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Division of Vital Records, talor Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	e Be	examiner? 1 ✓ Yes 2 No	oital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA	Other Nurs	ing Home 5 F	Residence 6 🗸 Oth	er; Scene
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Division pital or Atten ours after death eral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At (Specify)	home, farm, str	eet, factory, office	building, etc.	or Town, St		tural Route Number, City
Hospit 14 hour Puners		29a. Certifier Certifying Physician:	To the best of my knowle	edge, death occi	urred at the time.	date and place, ar	d due to the cause	e(s) and manner as sta	uted.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tranking the detached for the contraction of the page 2.	Medical	one) 2 Medical Examiner:On	the basis of examination d manner stated.	and/or investig	ation, in my opinio	on, death occurred	at the time, date a	nd place, and due to t	he cause(s)
H 3 H 3	ž	29b. Signature and title of certifier	C.C.			se number		29d. Date signed (M	onth, Day, Year)
		Mougene me	Knell		0.0	.M.E.		May 14, 2011	
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State Registrar Margarita Korell MD.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Certificate of Death Control C					State of Man				_		_	
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Privician Medical Examinor Pr	3alt	Depart Mport Iny inj		21. Signature of Funeral Service Licens	ee	22	. Name and Addre	ess of Facility	Raymor			
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Modical Examiner Page Pag		Physician/		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.			ig, seen as saidias	or respiratory as	,,		Interval Between
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Registrar MAI - 9 2011 Clause B. Backs				31. Date filed (Month, Day, Year)	32. Registre's	Signature 8.	bares	p				

Amended item #17 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per F.H. 5/5/11 cs State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 28° 2019 5:10A M Lowdermilk Amanda Lela Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Oakland Nursing & Rehab. Oakland Garrett Center Social Security Number If Under 1 Year _ If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 XF Min. Hours Maryland Director 215-78-3962 94 Usual Residence of Decedent 10a. State 10b. County ral", or items 23a or 28a-f sho Ex miner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Friendsville MD Garrett 10e. Street and Number 10g. Citizen of What Country? Funeral 453 Sand Spring Road 21531 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 X Widowed 4 □ Divorced White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked of VanSickle and 2 should be -Lowdermilk Samuel Ella Uphold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Nancy Arsenberger/Daughter P.O. Box 161, Mill Run PA 15464 Department of Healtl Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 s Date 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Blooming Rose Cem ! 4 Donation 5 Other (Specify) 5/1/11 Friendsville, MD Signature of Funeral Service Licensee Newman Funeral Friendsville, Vietten 943 Ave., 2nd 23a. Part 1. Enter the disease, or complications to trust ed shock, or heart failure. List only one cause on ed the death. Do not enjer the mode of dying, such as cordiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of Exami and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Year Pregnant at time of death 5 Other (specify) Day 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 🗌 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 Tes 2 🗌 No 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

e Hospital or Attending Physician: The law requires that the death certificate be real parts after death.
24 hours after death.
e Funeral Director: After this certificate has been signed by the attending physicia

State Registrar

Medical

29a. Certifier

(Check

only one) 29b. Signature and title of certifier

Thomas Johnson 31. Date filed (Month, Day, Year)

3 🗌

determined

15

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the Dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Day, Year) 29d. Date signed (Month, 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

311 N. Fourth St., Oakland,

Registrar's Signature

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 201 Robert F. Leath, Jr. 04:00 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Manor Healthcare Center Rising Sun Cecil Social Security Number 8. Date of Birth (Month, Day, Year) Nov . 25 . **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 1 XM 2 □ F Hours Director 201-24-4145 80 Pennsvlvania Nov. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importanti, if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic area. 10b. County 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2XXNo Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1881 Telegraph Road 21911 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married X Yes Yes, Give 2 No ive Army Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Gift Card Shop Owner Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert F. Leath, Sr. Ethel Huber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores P. Leath / Spouse 99 Cherry Lane, Perryville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mayerdale Crematory | May 7, 2011 | Newark, Delaware 21. Signature of Funeral Solice icens 22. Name and Address of Facility Crouch Funeral Home, P.A. 127 South Main Street, North East, Maryland21901 Part 1. Enter the disease, plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph, sician/ daus disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 2 No Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 ☐ Could not be Suicide Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: filled in by the funeral director, 24 hours after death. Funeral Director: A

Certificate:

Medical

29a. Certifier (Check

only one)

3 [

within 24 hours to the Fune completed file the

State Registrar 29b. Signature and title of certifier

critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

City or Town, State)

pleted cause of death (Item 23a) (Type, Print)

determined

ONIAL Way, Rising Sun, 101 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Ma	arylanc	-		nt of Health te of Death			giene Reg. No. 🔿		
	Physicia	n/	Decedent's Name (First, Middle, La	ast)						2. Date of Dea	ith 🐇	Year	3. Time of Death
-	Medic	al	Carolyn C. 4a. Facility Name (if not institution, give				4h Cih	, Town, or Locatio	n of Dooth	Month May	1	2011 nty of Death	12:16 PMM
	Examin	er	301 Skyview Road	,			4b. Oily	E1kton	ii oi beatii			Cecil	
	Funeral Director		5. Social Security Number 6. 233–48–6784	Sex 1 □ M 2 X F 7. Age	e (In yrs. las	st birthday) Yrs.	If Unde Months		er 24 Hrs. Min.	8. Date of Birth Month Day July 8		9. Birthp Coun West	olace (State or Foreign try) Virginia
	nd now at.	_	Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Loc	cation					1	0d. Inside City Limits
	farylar Ba-f sh tified	Director	Maryland Cecil			kton							1 🗆 Yes 2 🔽 No
	the Na or 2		10e. Street and Number			LICCOII	10f. Z	p Code			10g. Citizen o	of What Cour	ntry?
	th with ms 23 must	Funeral	301 Skyview Road					21921				ted St	
Maryland 21215-0036	within 72 hours after death with the Maryland jiene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 🏚 Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2XX If Yes, Give Year or Dates.	ver in U.S. No	lf If	f Yes, spe	edent of Hispanic Cecify Cuban, Mexice 2XXNo Speci	an, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ lack, White, o ify: Whi	etc.
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	2 등 2 후		19a. Informant's Name/Relationship (Ann Ferrazzo / Da	71				is (Street and Num iew Road				, State, Zip C 2192	
Baltimore,	permit. Page 1 and in Department of Heali Important: If item any injury or other once.		20a. Method of Disposition 1 Durial 2XX Cremation 3	Removal from State	cei	ace of Dispos metery, crem	natory or	other place)		Date	20c. Location	•	·
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Ba	Depar Impo any ir		21. Signal of fine the fice (cer	15		1	27 S	nd Address of Fac	n Str	uch Fun eet, No	eral Ho rth Eas	ome, P st, Ma	.A. ryland21901
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760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and executed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter the certying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a d.									
. Box 68	requires that the death certific been signed by the attending should be detached for use as	Σ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of Live Birth 1 Pregnant at 9 Unknown	2 🗌 Fetal	death 3	Ectopic Other (s	pregnancy specify)				Date of delive	ery Day Year
P.0	that t	by P	Part II. Other significant conditions	contributing to death bu	ut not resul	Iting in the u	nderlying	cause given in Pa	ırt I.	23e. Did to	bacco use co	ntribute to th	ne cause of death?
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of V	y Phys er this eral dii	e: To	1 ☐ Yes 2 🗷 No 27. Manner of Death	28a. Date of injur	у 2	R/Outpatien 28b. Time of		28c. Injury at		ome 5 Kesid 28d. Describe h)
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Divisi	al or Attending s after death. Il Director: After ed in by the funer	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		ry - At hom . (Specify)	ne, farm, stre	eet, facto	ry, office		28f. Location (S City or Town		ber or Rural	Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completed filled in by the funeral director, page 2.	Medical	(Check 2 Medical Exar	ysician: To the best of miner: On the basis of exrse Practioner; To the basis	camination a	and/or invest	igation, ir	my <mark>opinion, de</mark> ath	occurred a	t the time, date ar	nd place, and o	due to the cau	use(s) and manner stated.
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	16		30. Name and address of person who	1 700 C	/ <		. /	Elkto	r a	0 2	1921.		
	Stat Registra	e ar	31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	park							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend #19b, 5-16-2011, per FHDR entiricate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 6 20 1 Month Mildred L. Lesher 10:30PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Heartlands Senior Living Ellicott City 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last hirthday) 8 Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 🕮 Months Days Hours 6-19-1918 Director MD 578-07-7831 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Ellicott City Howard 10e Street and Number 10g. Citizen of What Country? Funeral with 21043 United States 3004 N. Ridge Road within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Banking Secretary other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental ! is marked o မ Marion L. Covey Bessie Aaron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2824 Stanswick Ct Ellicott City MD 21043 David C. Lesher III/son 20b. Place of Pispositis Canasway Ct: Ellicott City, MD 21043 20a. Method of Disposition cemetery, crematory or other place ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cem Easton MD 4 Donation 5 Nother (Speniffentombment 05/12/2011 21. Signature of Fun ral Service 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Dementia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): and -transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a hed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Tetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) should be detached 9 Unknown by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 s has autopsy performe 1 Yes 2 No certificate or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 🖫 Other (Specify) ASSISTED 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes within 24 hours after death To the Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 Certifying Physician: 29a, Certifier to the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

It he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Medical Examiner: 3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) D47447 May 9, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Lazris, MD 6334 Cedar Lane Suite 103 Columbia, MD 21044 31. Date filed (Month, Day, Y

State

Registrar

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Manyland, Department of Department Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month May 8, 2011 Physician/ Miller Bettv Maxiene 4:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death New Hope Assisted Living Allegany Cumberland 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs Months Days Hours Min. Funeral 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 1 🗆 M 2 🗆 E (Month, Day, Year)
Mar 16. **Director** 218-12-5787 MD 86 Usual Residence of Decedent 23a or 28a-f show ist be notified at 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Allegany Cumberland 1 ☐ ★es 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11609 Bierman Drive er than "natural", or items 23 the Medical Examiner must 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Specify: 3 Midowed 4 Divorced Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " College (1-4 or 5+) Elementary/Seconday (0-12) C&P Telephone Co Supervisor permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ruth (Robinette) Hess Ernest Hess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Wayne Lockard Sr. Son 2013 Evitts Creek Road Bedford PÀ 15522 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Restlawn Memorial Gardens 1 XBurial 2 Cremation 3 Removal from State 5/11/2011 MD LaVale 4 Donation 5 Other (Specify) 21. Sonature of Juneral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 nter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Approximate Interval Between Onset and Death shock or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours and set death.

Funeral Director: After this certificate has been signed by the attending physician and beed filled in by the Inneral director, page 2 should be detached for use as the Durial-Itansii filed in by the Inneral director, page 2 should be detached for use as the Durial-Itansii that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 1 No 1 Tyes Yes 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) NEW HOPE examiner? Hospital 2X No Other မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. /3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

fair

31 Registrar's Signature

Estuardo Elfido I	Mora	eles State of Maryland / Departme			2011 1635
		1- For State Certifica	ate of Death	Reg. N	1 2 4 4
Physicia Medical Exami	ın/	1. Decedent's Name (First, Middle,Last) Elfido Estuardo Morales Y	. Morales	2. Date of Death Month Day May 1, 2011	y Year 3. Time of Death 1242 hrs
		4a. Facility Name (if not institution, give street and number) Prince George's Hospital Center	4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth none 1 M 2 F 31	nday) If Under 1 Year If Under 24Hrs Months Days Hours Min	_	M/DD/YYYY 9. Birthplace (State or Foreign Chaptemala
id haw any ee.		Usual Residence of Decedent 10a. State	or Location erdale		10d. Inside City Limit
the Marylar a nr 28a-f i tified at on	Director	10e. Street and Number 5729 67th Avenue	10f. Zip Code 20737		Citizen of What Country? Guatemala
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit. Pages I and Anontal Hygiene. Impartant: If item 27 is marked other than "natural", or items 23a nr 28a-f shnwinjury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced or Dates:	13. Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puerto Guatema 1 X Yes 2 No specify:	Rican, etc.) Lan	14. Race - American Indian, Black, White, etc. White Specify:
1036 vithin 72 hours : ene. er than "naturr Medical Exami	mpleted	Elementary/Secondary (0-12) College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of voluming most of working life. DO NOT use reting the stabler with the stable of the st	red)	window Co.
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	2	17. Father's Name (First, Middle, Last) Juan Jose Morales Ramirez	Santos		Morales Chacon
MD 2. nd 2 should lith and M m 27 is m; aumatic e	2	Dimas Augusto Osorio Najera	Mailing Address (Street and Number or I 5729 67th Avenue Disposition (Name of cemetery,	Riverda	c. Location - City or Town, State
Baltimore, semit. Pages 1 ar Department of Hee Impurtant: If ite injury or other tr		1 X Burial 2 Cremation 3 X Removal from State Gene:	ral Cemetery 5/	11/2011	LaUnion,Zacapa, Guatemala
		21. Sometime of Pineral Service Limites	PHILIP OF RENALD 9241 Columbia B	FUNERA	L SERVICE,P.A. er Spring,Md2091
Physician Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do no failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Blunt Force Injuries	enter the mode of dying, such as cardiac o	r respiratory arrest, s	shock, or heart Approximate Interval Between Onset and Death
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Box 68760, e death certificate be the attending physicia ed for use as the buria		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregna Other (Specify)	ancy	23d. Date of delivery Month Day Year
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ion of Vit tending Physic eath. tor: After this c	on: To B	Month, Day, Year)	ime of Injury 28c. Injury at Work?	28d. Describe how Passenger auto	
Divisior pital or Attencours after death	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local Street	rm, street, factory, office building, etc.	28f. Location (Stree or Town, State) Riverdale Road, F	et and Number or Rural Route Number, Cit Riverdale, MD
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier (Check only one) 2			
3	æ	29b. Signature and title of certifier	29c. License number O.C.M.E.		d. Date signed (Month, Day, Year) ay 2, 2011
		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner	900 W. Baltimore Street, Baltin	nore, MD 21223	l
St Regist	ate rar	31. Date filed (Month, Day Year) 2011 32. Registrar's Signatu	parla		

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	•	For State Registrar		State of Ma	aryland				ieaith and Death	ı ivie	-	gien Reg. N	-		16	355
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Funeral		5. Social Security N		Sex 7. Age	e (In yrs. la	st birthday)		er 1 Year	If Under 24 H	in. 8.	Date of Bir (Month, Di	rth				e or Foreign
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Men Men arke	၉	Clarence	e Moore,	Sr.					Lula S	mit	n					
2 shc and is m		19a. Informant's N	Name/Relationship	(Type. Print)		19b. Mailir	ng Addres	ss (Street a	and Number o	Rural F	Route Numb	ber, City	or Town, S	State, Zip	Code)	
and ealth n 27		Rita Moo	ore/wife						t, Fore	stv	ille,					
of H of H if iter	- 1	20a. Method of Dis		Removal from State	20b. Pi	ace of Dispo	sition (Na natory or	ame of other plac	e)	Date	е	20c.	Location - C	City or To	wn, State	
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To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only one)		Physician: To the best caminer: On the basis of and manner st	of examinat											e(s)
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		30. Name and add	dress of person wh	no completed tales of d	death (Item	23a) (Type,	Print) 0	W) [EM	219	A> 27	200	17 -	sin	カルノ	7
Stat	e	31. Date filed (Mo	onth, Day, Year)	82. Registr	ar's Signat	ure ,	144	7	1001	-111)	< U >	7			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ inda McClure 1820 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Country) Maryland 1 M 2 Tx F Days Hours 10/13/1939 Director 216-36-8042 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Shady Side 1 🗌 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1247 Avalon Blvd 20764 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black White etc Completed by 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify. Specify: White 3 X Widowed 4 Divorced item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 10 Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Erling Anderson Ruth Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 shou Health and tem 27 is n Beverly Simpson/Daughter 1247 Avalon Blvd., Shady Side, MD 20764 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lee Crematory 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) May 10, 2011 Clinton, MD 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8200 Jennifer Lane, Owings, MD 20736 Signature of Suneral Service Licensee Lisa M. Mounts 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Burall bowel disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner heruia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of): physician s the burial Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No Day Month Year 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 K No ၉ 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After work? injury 1 Natural 5 Pending 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 12061383 2011 completed cause of death (Item 23a) (Type, Print) 30 Name and address of person who e Frederick imp 201678 HOSPITEU 70 Princ MA

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 21. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 NAAM MulcHAR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 12902 Sutters Lane Prince George's Bowie 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Lebanon 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 M 2 F Days Min Months 02/2071959 273-74-8457 52 Vrs Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location Director MD Prince George's Bowie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 12902 Sutters Lane 20720 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 XNo 'natural", or 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home other traumatic event, Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည Salim Roueiheb Martha Merheb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sami Mukhar/ Spouse 12902 Sutters Lane, Bowie, MD 20720 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Resurrection Cemetery: 05/06/2011 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or co shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, not one cause on each line. Immediate Cause (Final Physician/ Ken disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami that the death certificate be executed bunial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 Yes 2 No 9 Unknown Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 24a. Was an page 2 s autopsy To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 X No Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 🗾 Natural work? 5 \square Pending 2 🗆 No Accident Suicide Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the b 29b. Signature and title of cert/fi

23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated o completed cause of death (Item 23a) (Type, Print) Registrar's Signature **ORIGINAL**

3. Time of Death

10d. Inside City Limits

Approximate Interval Betweer

P9503107974 S

USA

White

1 Yes 2XX No

Registrar DHMH 17 Rev 7/2009

State

Name and address of person

32

6 2011

MILLIT 31. Date filed (Mor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Clyde Junior Marsh 10:40 a.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death WM Regional Medical Center Cumberland Allegany If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. 7. Age (In yrs. last birthday) Sex 1.XXM 2 □ F 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 220-26-9585 Months Aug. 28 ^{rea}(930 Mary Land Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Westernport 1 ☐ Yes 2X No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 21562 Funeral 21904 Arnold Lane SW United States filed within 72 hours after death Was Decedent Common Armed Forces?

1 XX es 2 No No No Give Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black White, etc. \$ 1 Never Married 2XXMarried Maryland 21215-0036 white 1 Yes 2XXNo Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Construction Elementary/Seconday (0-12) College (1-4 or 5+ Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of ၉ Clyde Marsh Gladys Miller permit. Page 1 and 2 should be Department of Health and Menr Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21904 Arnold Lane, Westernport, Maryland 21562 Maria Marsh/ wife Baltimore. 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Philos Cemetery 20c. Location - City or Town, State Page 1 s 05/11/2011 1 X Burial 2 Cremation 3 Removal from State Westernport Maryland 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 7. Wupe Bor 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Cieca Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day Year signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a, Was an Jas page 2 autopsy performed death? certificate 2 No 1 Yes ☐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical of Vital completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending Division 1 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Certifying Nurse/Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Vikramaditya Poonai, 924 Seton Drive, Cumberland, MD 21502 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

MAY 1 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Joseph Montgomery Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cumberland Allegany WM Regional Medical Center Social Security Number 7. Age (In yrs. last birthday) 74 Yrs. If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Funeral 216-34-6056 Months Days Hours Min May 13 1936 1 **XX**M 2 □ F Maryland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Fyaminar must have also any injury or other traumatic event, the Medical Fyaminar must have also as a second and injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director WV Mineral Keyser 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RR 1 Box 225 H Old State Road 26726 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Paper Manufacturer Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname)
Geraldine Wilt 17. Father's Name (First, Middle, Last) ည Edwin Thomas Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Montgomery/ son RR 1, Box 225 J, Keyser, West Virginia 26726 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cumberland Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 05/10/2011 Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Bram Stem disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year g Unknown signed by till be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗆 Yes 2 🔀 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🜠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 0 0 0 6 8 4 5 5 5,9,11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12500 millowbrook road, cumberland MD Enkeshafi. Ardulan 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 0 2011

DHMH 17 Rev 7/2009

Registrar

		For	State of Ma	ryland /	Department of I	Health and N	/lental Hyg	giene	
		1 - State Registrar			Certificate of	Death	F	Reg. No. 7	1 1 (2 (0
		1. Decedent's Name (First, Middle, La	ast)				2. Date of Dea Month	th Day Year	3. Time of Death
Physi /Med		Clare C. McNift	E				May	8 2011	6:30 a ^M
Exam		4a. Facility Name (If not institution, given	ve street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	
		Encore at Turf	Valley		E	Ellicott C	ity	Howar	d
Funera	al	5. Social Security Number 6. 8	Sex 7. Age	(In yrs. last bi	rthday) If Under 1 Year Months Days		8. Date of Birth	h 9. Bi	rthplace (State or Foreign Country)
Directo	or	030-20-0214	1□ M 2 X F	69	Yrs.	110010	11/13/	1941	RI
pui 🔥		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	up or Logation				10d, Inside City Limits
aryla	5	MD Howard			lumbia				1 □ Yes 2 XNo
he M	Director							40. 0:1:	
with t		10e. Street and Number 8856 Warm Granit	- Drive		10f. Zip Code	.045-5950		10g. Citizen of What C United	-
15-0036 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Extrainer must be notified at	Funeral						anife Van au Na		
er de	Ë	11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 [Yes 2] N		13. Was Decedent of I If Yes, specify Cub	pan, Mexican, Puerto	Rican, etc.)	14. Race - Am Black, Whi	
IS aff	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	0	1 □Yes 2 X No	Specify:		Specify:	White
5-0036 72 hours aft natural", or		15. Decedent's E		168	i. Decedent's Usual Occur	pation		16b. Kind of Business	s/Industry
Z15 thin 72 ie.	Completed	(Specify only highest gr	ade completed)		(Give kind of work done life. DO NOT use retire	during most of work	ring		·
	E	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Educato	or		Educat	ion
	Be C	17. Father's Name (First, Middle, Last	1)			18. Mother's Nam	e (First, Middle,	Maiden Surname)	
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IOCE, Marylan ges 1 and 2 should be it of Health and Mental if item 27 is marked or other traumatic ev	-	19a. Informant's Name/Relationship	(Type. Print)	19	b. Mailing Address (Street	t and Number or Rui	ral Route Numbe	er, City or Town, State,	Zip Code)
2 5 # 2 T		John Joseph McNif	f - husban	ıđ	8856 Warm G	Granite Dr	ive Col	umbia, MD	21045
s 1 and 3 Health item 27 other tr		20a. Method of Disposition		20b. Place of	of Disposition (Name of ery, crematory or other pla	>	Date	20c. Location - City o	r Town, State
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₽ ₽₽₽₽	di)	21. Signature of Funetal Service Lice		ALTHR	22. Name and Addre	ess of Facility Har	0/2011	itzkele Fa	mily F.H.Inc.
and per	once	MANOTA	MALO	MMQU	5 4112 01d C				
		23a. Part 1. Enter the disease, or or	nnlications that caused	the death. Do	V'			*	Approximate
		shock, or heart failure. List only Immediate Cause (Final	one cause on each line	e.	1.5				Interval Between Onset and Death
⊶ Physiciaı Medica/	_	disease or condition	Meto	1 5 / 0					Onset and Dodan
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	r	resulting in death) Sequentially list conditions,	Due to (or as a	a consequence	of):	na Co	ance	2.	
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	30. Name and addre	ess of person who co	ompleted cause of d	leath (Item 23a)							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Year May Evelvn В Nickens 6:08 A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4003 23rd Parkway # Temple Hills Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗹 F Months Days Hours Min Wash.,D.C. 0872374921 579-22-1148 89 Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits Md. P.G. Temple Hills 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral # 1 4003 23rd Parkway 20748 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🔀 No Specify Black 3 ☐ Widowed 4 ☐ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry U.S. Navy Dept. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government 8th Machine Operator Apprentice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Clarence S. Bell Mary Jane Hickman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nymber or Rural Route Number, City or Town, State, Zip Code) Lola V. Ellis/Great Niece 4003 23rd Parkway, Temple Hills, Maryland 20748 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05/13/11 Lincoln Mem. Cem. Suitland, Maryland Signature of Funeral Service Licensee ^{22. Name and Address of Eacility} Henry S. Washington & Sons Co., Inc. Same 4925 Burroughs Ave., N.E. Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 6 months Dementia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and if be detached for use as the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy after death.

Director: After this certificate 2 No 1 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Tyes 2 🔀 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 1/🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 27521 May 4,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kadie E. Leach, M.D. 9500 Annapolis Road # A-1, Lanham, Maryland 20706 31. Date filed (Month, Day, Year)

AAY 0 9 2011 32. Registrar 's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Veronica Osorto Physician/ Dalia May 1, 20111032 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist 5. Social Security Numbe If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Manth, Day 9. Birthplace (State or Foreign Age (In vrs. last birthday **Funeral** 1 □ M 2 🔀 F Months Efoursalvador 3 Mans Par 9977 34 Director Usual Residence of Decedent or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Rockville MD Montgomery 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a on any njury or other traumatic event, the Medical Examiner must be a by Funeral El Salvador 20853 4608 Harlan Street Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc.
White 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No El Salvadoran Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Cook Be 18. Mother's Name (First, Middle, Maiden Surname)
Flor De Maria Goche 17. Father's Name (First, Middle, Last) ည Carlos Guzman 19a. Informant's Name/Relationship (Type, Print) Hysband German Osman Osorto/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4608 Harlan Street Rockville, Md 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State San Rafael, LaPaz, El Salvador 20a. Method of Disposition 5/9/2¹011 1 M Burial 2 Cremation 3 Removal from State Municipal Cemetery 4 Donation 5 Other (Specify) PHITE TOPA OF SERVICE, P.A. 21. Signature of Funeral Sec Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line.
lediate Cause (Final ase or condition Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Melanoma To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-transi metastatic that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 - Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ■ Yes 2 □ No Year Pregnant at time of death 5 Other (specify) 9 Unknown been signed by the should be detached 27 2010 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 death?
1 Yes 2 No perform 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural 5 Pending ☐ Accident☐ Suicide Investigation within 24 hours after deatl To the Funeral Director: Xcompleted filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ,2011 may 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Otr Dr Rockville, MD 20850 Dana 9901 Julie DO 31. Date filed (Month, Day, Year) Registrar's Signat State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 29, 20 1 1 12:30 p M Kenneth Leroy Owens Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 911 Leadenhall Street **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 XM 2 □ F Months Days Hours Month, Day, June 28, Country) Director 212-76-5668 53 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10d. Inside City Limits **Funeral Director** must be notified 1 X Yes 2 ☐ No MD **Baltimore** 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 911 Leadenhall Street 21230 USA 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Force: Black, White, etc. "natural", or 2 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 - Widowed 4 - Divorced Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) event, the Construction Laborer Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Julius Washington Boots Bertha Mae Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Owens - sister 1503 North Eden Street, Baltimore, MD 21213 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State matory or other place, mportant: If injury or Carroll Western Cemetery May 7, 2011 Prince Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. Dlades 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Be Completed by Physician/Medical Examine Due to (or as a consequence of): the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Other (specify) 4 Pregnant
9 Unknown Pregnant at time of death Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy perform certificate 2 🗌 No Yes Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) funeral Certificate: 27. Manner of Death 28c. Injury at Natural 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation s after death completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated R084666. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20, 419 WREDWOOD ST dRW 3 Khalla,

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Arbril 1030PM Lelia V. Powell 20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏻 F Days (Month, Day, Countr Wirginia 224-28-9676 Months Hours Min. 86 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c City Town or Location with the Maryland 10d. Inside City Limits Director Baltimore 1X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1735 East Lafayette Ave 21213 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify Specify:Black Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Medical Dental assistant 12 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Albert Weaver Emma McClenny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2075 Jonesboro Rd Kenbridge, VA 23944 Jacqueline S. Moore/niece 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 5/2/2011 Chesapeake, VA 4 ☐ Donation 5 ☐ Other (Specify) Roosevelt Memorial 21. Signature of Funeral Service Licensee s Funeral home Latney' 22. Name and Address of Facility CC 0278 3831 Georgia Ave. NW Washington, DC20011 23a. Part 1. Unter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition set and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buring Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 Yes 2 No Month ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. nas been signed be 2 should be deta 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) . Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Completed filled in by determined 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 00063163 and address of person who completed cause a death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05/01/201 SYDNEY EDWARD PERRY, JR. M 0559 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgamery If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 | F Hours (Month, Day, Year) Director 230-52-7003 Usual Residence of Decedent shov 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No VA Hampton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21 Azalea Drive 23669 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Armed Forces? 1 XYes 2 □ No 1958-If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married Black, White, etc. 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced 1978 Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education and Mental Hygie is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Beatrice Drew Sydney Edward Perry, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Department of Health Important: If item 27 any injury or other tr Azalea Drive, Hampton, VA 23669 Novella R. Perry/wife Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) 05/10/11 Hampton Mem. Gardens Hampton, VA 1. Signature of Funeral Service Lige 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ car disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner cardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cancel 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes ours after death.

eral Director: After this certificatiled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🗹 No Other: 1 Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Prantioner: To the best of my knowledge idat the time, date and place, and due to the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1901 medical center Dive, Rockville, Mary land 20850 carpenter, mp 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 05 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jacob D. Pindell Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Anne Arundel Center Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth

(Month, Days)

Feb 28 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ØM 2 □ F Months Hours Min. ^{′ear}1923 Maryland Director 216-16-4677 88 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 216 Pindell Ave 21401 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married <u>ਨ</u> 1 ☐ Yes 2X No Specify: Black Completed 3 Widowed 4 Divorced Year or Dates. 1943 – 46 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry United States Elementary/Seconday (0-12) 12th College (1-4 or 5+) Naval Academy Presser Machine Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic ew Lillian C. Smith Jacob Pindell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, Md. 21401 216 Pindell Ave Sally V. Pindell(Wife) 20a. Method of Disposition 20b. Bestopstion (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Memorial Park 5-5-11 Annapolis, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Miname a Recension Facility Sons Mortuary, P.A. Xa West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed rewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2- No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 HNo 1 Yes မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No injury 1- Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner; to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and titlerof certif 29c. License number Date signed (Month, Day, Year) 4+1

Registrar DHMH 17 Rev 7/2009

State

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Gary Lee Pielemeier Physician/ Month Year May 2011 Medical 1:50 4a. Facility Name (if not institution, give street and number)
Anne Arundel Medical Center Examiner 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Social Security Number 295–28–9448 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Ye Sept. 10, If Under 24 Hrs. 9. Birthplace (State or Foreign 1 **X**MM 2 □ F Months Days Ohio 1931 Usual Residence of Decedent show Maryland ral", or items 23a or 28a-f shor Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director Anne Arundel Arnold 1 Yes 2XXNo 10e Street and Number 1268 Masters Drive 10f. Zip Code 10g, Citizen of What Country? Funeral 21012 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2XXMarried 1 ☐ Yes 2XXNo Specify: If Yes, Give 1961–91 Year or Dates. "natural", White 3 Widowed 4 Divorced Specify traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Professor Education Be 17. Father's Name (First, Middle, Last)

Harold E. Pielemeier 18. Mother's Name (First, Middle, Maiden Surname) 2 Virginia Glynn 19a. Informant's Name/Relationship (Type, Print)

Judith Pielemeier/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1268 Masters Drive Arnold, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State Baltimore Crematory 5/6/2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Throat Cancer disease or condition resulting in death) Due to (or as a consequence of) COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the hurial Physician/Medical the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Wunknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy Yes 2 X No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 🗌 Yes 2 XXNo 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XXNatural 5 \square Pending 2 Accident 1 🗌 Yes Investigation 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Funeral Director 72 hours after death Baltimore, Maryland 21215-0036 d Mental Hygiene. marked other than permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat Physician/ Medical [©]Examiner Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 within 24 hours after deatl To the Funeral Director: Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Excertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatu 29d. Date signed (Month, Day, Year) R135106 May 4, 2011 30. Name and address of person who complete use of death (Item 23a) (Type, Print) Jennifer Frey 2001 Fidewater Colony Drive Annapolis, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State MAY 05 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#1 per PHY State of Maryland State Registrar 5/6/2011 aaco health dept. CMH Certificate of Death Reg. No. Joann D. Potts 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day OTTS 9.00 PM 2011 May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death HERITAGETHARBOURENURSING & ANNAPOLIS ANNE ARUNDEL Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days 1 □ M 2**X** F Min. Hours Director 191-24-2304 81 02/22/1930 ILLINOIS Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ns 23a or 28a-f shov must be notified at Director 1 ☐ Yes 2 X No MARYLAND ANNE ARUNDEL ARNOLD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with items 23a 1214 TRIBAL COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 No þ Specify. 3X Widowed 4 ☐ Divorced WHITE Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) Health and Mental Hygiene. tem 27 Is marked other thar 12 SECRETARY ADMINISTRATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ CHRISTIAN ANTHONY DANIELSEN MAE POWER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 | SHARON POTTS/DAUGHTER 1214 TRIBAL COURT, ARNOLD, MARYLAND 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o once. ō 1 XBurial 2 ☐ Cremation 3 ☐Removal from State CONESTOGA MEMORIAL 4 ☐ Donation 5 ☐ Other (Specify) 05/09/2011 LANCASTER, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility P. Tr1. Enter the disease. — complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. ardiovascular Immediate Cause (Final disease or condition Physician disease or condition resulting in death) + Thero LC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enfer Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exam g physician and sthe burial-tr Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has tirector, page 2 s autopsy performe 1 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 No P 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 ☐ Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide . Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30641 land 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chanaltus 2n1-109 Book RWW Med Road 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 16370 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John William Parks Month 2345 M 05 Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death upper chesapcele nosnital BelAir Harkova If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 7 F Days Hours Min. 218-26-4478 80 Director June 24. °F930 Mary Tand Usual Residence of Decedent shov 10a. State 10h County notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Maryland Baltimore Perry Hall 1 🗆 Yes 2 💢 No ò 10e Street and Number 10f. Zip Code 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 10g. Citizen of What Country? Funeral 4506 Sandra Lake Rd. 21128 USA death v 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. 72 hours after 1 X Yes 2 ☐ No If Yes, Give 1 C Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Completed 3 Widowed 4 Divorced Year or Dates. 1951-54 Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other the 12 Assembly Line Worker Automotive/GM Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic o Charles Parks Theresa O'Donnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tom Parks-SON 310 Bourbon St., Havre de Grace, MD 21078 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Washington Crem May 5, 2011 Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Rd, Laurel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for or Attending Physician: The law requires that the death certificate be executed -transit Cause (Disease or linjury that initiated events and resulting in death) Last Due to (or as a consequence of): the burial attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Yes 2 No the 9 Unknown 9 Unknown sate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

al Director: After this certificate ha autopsy perform репоrmed Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Tyes 2No Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title & 29c. License number D76751 05/04/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - Devic, Bultin MD 2014 Aashe sethi 200 all chesopolice 31. Date filed (Month, Day, Yea, State istrar's Signature 6 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 04 ŽT11 8:15 p M Horace Peebles Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Upper Marlboro 226 Weymouth Street Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday) **Funeral** 1 🕱 M 2 🗆 F Months Days Hours Min 02771271 937 North Carolina Director 242-52-2540 74 Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 1 🔀 Yes 2 🗌 No Prince George's Upper Marlboro ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 20774 226 Weymouth Street death v 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2 2 1

1

Yes 3 1

Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc permit. Page 1 and 2 should be filed within 72 hours after C Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 **Black** 1 Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Montgomery County School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Myatt Millard Peebles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Upper Marlboro, MD. 20774 226 Weymouth St. Angela Abdullah - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 5-5-2011 4 Donation 5 Other (Specify) MD Cheltenham, MD Veterans Cemetery 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service License 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final > Physician/ Non Hodokins Lymphoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending p for use as t IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death ed by the a detached f g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy certificate ha death? 1 ☐ Yes 2 ☐ No Yes 2X No Be (25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) 1 🗌 Yes 2 🔀 No Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? X Natural injury 5 Pendina after death. Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in by determined 24 hours Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s continuing Murse Practioner) to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. d/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 2 4/29/2011 D0057042 NA

Registrar DHMH 17 Rev 7/2009

State

1221 Mercantile Lane

Largo, MD 20772

30. Name and address of person who completed cause of peath (Item 23a) (Type, Print)

Anita Clayton, MD

31. Date filed (Month, Day, Year)

MAY 0 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ GREGORY NELSON PARTHREE 2011 17:13p M Mav 16. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BETHESDA

If Under 1 Year | If Under 24 Hrs.

The I Days | Hours | Min. NATIONAL INSTITUTES OF HEALTH MONTGOMERY 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1**X** M 2 □ F Months (Month, Day, Year) av 26, 1966 Country) Director 214-02-4731 44 May DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 XNo MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 231 Devon Dr. U.S.A permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u> Tourneyman Electrician</u> Electrical Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Donald C. Parthree Patricia F. Vines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Ingram (wife) 231 Devon Dr. Chestertown, MD. 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Kent Cremation Services 5/18/11 Smyrna, DE. 21. Signature of Funeral Service Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. 21635 M00510 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or peart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final Physician/ Myelogenas Leuktmia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Completed by Physician/Medical Box 68760 use as yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed Yes 2 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 X No ည 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural iniury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse/Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0662 30. Name and address of person who completed cause of death (Item 29a) (Type, Print) Halverson MD 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 23 2011 Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Rinehart Dona1d E. 12:55 pM May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery Suburban Hospital Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 XM 2 ☐ F Months Days Hours Min May 28, 1940 Director 212-38-3477 70 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD 1 Yes 2X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 Funeral USA 11823 Idlewood Road 20906 72 hours after death with or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. 1 Never Married 2 Married ò 1 Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 A No Specify: "natural", Specify:White 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Electrical Be 17. Father's Name (First, Middle, Last) should be filed and Mental H 18. Mother's Name (First, Middle, Maiden Surname Carl Moore Rinehart Evelyn Elizabeth Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code S ye 1 and 2 sl it of Health a if item 27 is 11823 Idlewood Road, Silver Spring, MD 20906 Pamela L. Westman/Girlfriend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremat Metropolitan Crematory 4 Donatio Other (\$pecity) Alexandria, VA 21. Signature Francis J. Collins Funeral Home 500 University Blvd. W., Silver Inc. Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final MA Physician/ Onset and Death 11/1091 disease or condition Medical resulting in death) Due to (or as a consequence of) 'Examiner 55 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) D Exami sician and burial-trans resulting in death) Last Due to (or as a consequence of) 12011 Physician/Medical the death certificate be attending physic for use as the b IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 28 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 13 Month Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown TOWAL 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy **Division of Vital** the Hospital or Attending Physician: To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) PINEHART, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death To the Funeral Director: A Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

Medical

29a, Certifier

only one) 29b. Signature and

Atul Mohatgi, MD

MAY 05 2011

31. Date filed (Month, Day, Year)

30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 7/2009

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month. Day.

8600 Old Georgetown Road, Bethesda, MD 20814

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

31 2011

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:14 p M Bras Jose Raminhos Medical May 20114a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Feb. 6, 1924 Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Portugal 1. M 2 □ F 216-64-3862 Director 87 Usual Residence of Decedent show 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD 1 Yes 2 X No Montgomery Gaithersburg 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral marked other than "natural", or items 23a 458 Girard Street, Apt. 102 20877 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc 1 Never Married 2 K Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify. Specify: White 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ and Mental Hygiene. Tailor Clothing/Garments Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francisco Raminhos Maria Jose Teodoro 19a. Informant's Name/Relationship (Type, Print) S 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Miguel Raminhos/Son 20913 Scottsbury Drive, Germantown, MD 20876 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Important: If it any injury or o cemetery, crematory or other place, All Souls Cemetery 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Germantown, 22. Name and Address of Facility. Francis J. Collins Funeral Home 500 University Blvd. W., Silver 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Intracranial Hemorrhage Medical resulting in death) Due to (or as a consequence of) Examiner Edema Sequentially list conditions, if any leading to immediate Examine cause. Enter Underlying attending physician and d for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Malignant Due to (or as a consequence of) Physician/Medical Coagulopath atroa enic 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No ☐ Pregnant at time of death ☐ Unknown Month Dav Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed has e 2 s Be

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 n 24 hours after death, le Funeral Director: A bleted filled in by the fi within 24 ho

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Raminhos;

		1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed? 1 \(\text{Yes} \) 2 \(\text{No} \) No 24b. Were autopsy findings available prior to completion of cause of death? 1 \(\text{Yes} \) 2 \(\text{No} \) No
25. Was case referred to medical examiner?	26. Place of Death (Che	eck only one)
1 Yes 2 No	spital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing I	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Physicia (Check 2 Medical Examiner	an: To the best of my knowledge, death occured at the time, date and place, on the basis of examination and/or investigation, in my opinion, death occurred	and due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s) and manner stated

only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Amare Abebe, MD

MAY 05 201

D00052557

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMARE ABEBE 9901 Medical Car Dr Rockville MD 2050 31. Date filed (Month, Day, Year) 82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 3, 2011^{Day} 5:30 PM M Frances Raley Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Potomac Manor Care Potomac Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 - XF Months Days Hours Min. 578 01 4454 90 Director Washington DC Usual Residence of Decedent show 10a. State ural", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Montgomery Potomac 1 Yes 2 XX 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 10714 Potomac Tennis Lane 20854 United States 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give "natural", Completed Specify. 3 X Widowed 4 Divorced Year or Dates White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Congressional Liason other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Sherwood King should be Grace Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is i Suellen Paleologos (Daughter) 10721 Stanmore Drive, Potomac, MD 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery May 10, 2011 Clinton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Respiratory Failure Physician/ disease or condition Sudden Medical resulting in death) Due to (or as a consequence of): Examiner Restrictive Lung Disease Years Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence on Exami that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last attending physician a l for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown P.O. been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, Hospital or Attending Physician; The law requires Osteoporosis Completed 1 Tyes 2 ☐ No 3XX Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hypertension, Advanced Age 24a. Was an has page 2 autopsy performed Yes 2 certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

264

31. Date filed (Month, Day, Year) State Registrar

Medical

29a. Certifier

29b. Signature

only one

and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Loreto Albiol, M.D. 8218 Wisconsin Ave Suite #103, Bethesda, MD 20814

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

May 4, 2011

29c. License number

31

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	1	For State Registrar		State	of Ma	aryland	•	ırtmer <i>tificat</i>			l Mental H		ne No. 2 ()	Manager and American	16376	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status1 □ Never Married 2	☐ Marrie	12. Was Dece Armed For 1 \sum Yes	edent Evorces?	ver in U.S.	13. W	Yes, spec	ent of Hi	spanic Origin? (n, Mexican, Pue	Specify Yes or N rto Rican, etc.)	0-	14. Race - Black,	America White, et		
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shoul		19a. Informant's Name/Re					19b. Mailing	g Address	(Street a	and Number or F	Rural Route Num	ber, City	or Town, Star	te, Zip Co	ode)	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit. Medical Certificate: To Be Completed by Physician/Medical Exam		(Check 2 DMe	dical Exa	hysician: To the baminer: On the bas lurse Practioner:	sis of exa	mination an	nd/or investig	gation, in I	ny opinior	n, death occurred	d at the time, date	and pla	ace, and due to	the caus	e(s) and manner stated	
To th comp		9b. Signature and title of		A		- 21 21 1119 1511		_	License		,		Date signed (/			
,		D K-Y	(a)	li						D28352			May 1	0,20	11	

State

Krishan Mathur, M.D. P.O. Box 1703, La Plata, MD
31. Date filed (Month, Day, Year)
32. Refistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20646

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Samuel Steven Rochester, Jr. 11:25 AM Medical May 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death William Hill Manor Talbot Easton 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1**XX**M 2 □ F Days ^{Year)} 1<u>927</u> 212-22-4169 Oct. 11 83 Maryland Director Usual Residence of Decedent or 28a-f show notified at Maryland 10c. City, Town or Location Director 10d. Inside City Limits Anné Arundel Friendship 1 Yes 2XXNo 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral P.O. Box 166 20758 U.S.A. death \ 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1XXYes 2 No Maryland 21215-0036 hours after If Yes, Give Year or Dates. 1 Yes XXNo Specify. White 3 Widowed 4XXDivorced Specify: 1950-54 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 72 Elementary/Seconday (0-12) 12 College (1-4 or 5+) Owner Car Dealership 1 and 2 should be filed with if Health and Mental Hygien item 27 is marked other tt injury or other traumatic event, Be Father's Name (First, Middle, Last)
Samuel Steven Rochester, Sr. 18. Mother's Name (First, Middle, Maiden Surname)
Marie T. Flaig ည 19a. Informant's Name/Relationship (Type, Print)
Mary S. Lewis/executor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau P.O. Box 176 Friendship, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MDVeterans Cemetery ! 5/9/2011 Crownsville, Maryland 21. Signatura Service Acense 22. Name and Address of Facility John M. Taylor Funeral Home 0 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final End Stage Dementia Physician/ disease or condition years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician by Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No jo 4 Pregnant at time of death 9 Unknown Month Day Year signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Hypertension, Coronary Artery Disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXUnknown phone 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy perforr death? 1 Yes 2 No Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 XX Natural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

within 2 To the I

State Registrar

31. Date filed (Month, Day, Year) MAY 05 2011

(Check

only one 29b. Signature and time

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul M. Reinbold, MD 321 Bloomingdale Avenue 32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0053094

Federalsburg, MD

29d. Date signed (Month, Day, Year)

May 3, 2011

21632

29c. License numbe

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May Phyllis Ridge 2011 5:10 P. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 100 Burgess Hill Way Apt. Frederick Frederick 8. Date of Birth (Month, Day, Ye April 21 Social Security Number Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 1 □ M 2 X F Days Hours Director 188-32-0499 70 Pennsylvania Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗌 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 100 Burgess Hill Way Apt. 310 21702 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinano. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed XX Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 School Board Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard L. Harkins Margaret M. Magill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry W. Ridge, son 629 Naples Drive Allen, Texas 75013 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) St. Joseph Cemetery 05/09/2011 Derry, Pennsylvania 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Bert J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ 00 diac Medical Due to (or as a consequence of): Examiner SOPE Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence on or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ate has been signed by the atte page 2 should be detached for in the past 12 months?
1 Yes 2 No Year Dav Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed After this certificate 1 Yes 2 No 2 12 No 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) Hospital 1 Tyes 2 1 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 🗆 No Accident Sulcide Investigation **Director:** Could not be 6 🗆 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by To the Hospital or within 24 hours aft To the Funeral Dii Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkview Medical Group 10 Dr. Michael 31. Date filed (Month, Day, Costello, M.D 1564 Opossumtown Pike Frederick, 21702 Maryland

State Registrar

DHMH 17 Rev 1/2001

			1 - State State of Maryland / De Registrar	partment of Health and leartificate of Death		Annual Cor II II	16381	
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
	Physicia Medic		Ruth E. Morgan Rice		Month MAY	16, 2011	9:48P.M.	
	Examir		4a. Facility Name (if not institution, give street and number) Reeders Memorial Home	4b. City, Town, or Location of Death Boonsboro	1	4c. County of Death Washington		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda, 1 M 2 X F 97 Yrs.	/ If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Cour	place (State or Foreign ntry) vland	
_	, A	,	Usual Residence of Decedent				/	
	ırylan a-f sh ied a	Director	10a. State 10b. County 10c. City, Town or MD Allegany Frostbu				10d. Inside City Limits 1 Yes 2 □ No	
	or 28¢	Dire	10e. Street and Number	10f. Zip Code	10	0g. Citizen of What Cou		
:	ns 23a o	Funeral	141 Frost Avenue	21532		U.S.A.	muy;	
စ္က	", or iter aminer	þ	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify: 	pecify Yes or No- po Rican, etc.)	14. Race - Americ Black, White,	etc.	
Ş	ours a atural' cal Ex	Completed	Year or Dates.		ite ————			
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213	ygiene her tha t, the		College (1-4 of 5+) Own	er/Operator	(Gun Shop		
/land	permit. Page I and 2 should be lined within 72 hours after death with the Maryland beatment of Health and Mental Hygiene. Important if firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last) R. Hillary Lancaster	18. Mother's Nan E li zabe	ne <i>(First, Middle, Mi</i> e th E. Ri c	^{laiden Sumame)} chardson La	ncaster	
Baltimore, Maryland 21215-0036	alth and I			iling Address (Street and Number or Rui 27 Greenbriar Rd.		-	Code)	
ore,	e I and of Hea If item or othe		20a. Method of Disposition 20b. Place of Dis	position (Name of ematory or other place)		20c. Location - City or To	own, State	
<u>ti</u>	rtmeni rtant: rjury		4 Donation 5 Other (Specify) Frostbur			FRostburg,		
Ва	Depa Impo any i			22. Name and Address of Facility So 60 W. Main St., Fr			P.A.	
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687 ertifica	ing ph		IF FEMALE:					
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on o	or; Afte	ficat	1 ✓ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No		, ,		
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the H	ithin 24 the Fomplete	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier	, death occurred at the time, date and place	ce, and due to the ca	ause(s) and manner as st	ated.	
۲	Z, Y,		Pale Y Brell Peron / Physic	29c. License number	359 2	d. Date signed (Month, i	7 2011	
	00 0		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	ND 01750	301-432-	2222	
8 7	Stat	0		EEDYSVILLE, MARYLA		301-434-		
	Registra	ir	MAY 2 3 2011 Server 32. Registrar's Siscapped					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

RUTH E.

NAME:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Cayden Daniel Redden-Lewis Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kegional Medical Cente Salisbur reninsula WICOMICO Social Security Number . Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days May 14. Year 011 Country)
Maryland Director INFANT Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d Inside City Limits Director 1 No Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 605A Riverside Drive 21804 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White etc. ð 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72. In and Mental Hygiene. Is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) n/a n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Tiffany Redden Christopher Todd Lewis Lepartment of Health and Important: If item 27 is many injury or other any injury or other. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 605A Riverside Drive - Salisbury, MD 21804 Tiffany Redden/mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Coolspring UMC Cem. 05/18/2011 Girdletree, Maryland 22. Name and Address of Facility 1213 Jersey Road - Salisbury, M.D. 21. Signature of Funeral Service Licensee Jolley Memorial Chapel 21801 Part 1. Enter the disease, or complications that Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause of ach line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 1 1 1 1 1 2 1 Pregnant at time of death in the past 12 months? Month Day Vear 5 Other (specify) P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perforn death? Yes Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending injury Division within 24 hours after death. **To the Funeral Director**: A' completed filled in by the fu 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State: Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier signed (Month, Day, Year) D56204 Name and address of person who completed cause of death (Item 23a) (Type, Print) atherine Casto 100 E. Carroll

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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Herman Rodgers		State	of Maryland / Depa	artment of rtificate of		Mental Hy		20	6383
Physicia		Registrar 1. Decedent's Name (First, Middle,Las		Timeate of	Death		Reg. 2. Date of Death	No.	3. Time of Death
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		710 Baker Street			Salisbury			Wicomico	
Funeral		5. Social Security Number 6. Se		last birthday)	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth (I	MM/DD/YYYY) I	Birthplace (State or Foreign
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21215-0036 uid be filed within 7 Mental Hygiene. marked other than	Completed	17. Father's Name (First, Middle, Last)		4	borer	8.Mother's Name	(First, Middle, Mai	den Surname)	1709
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Divisior Bospital or Attend 4 hours after death Puneral Director: stely filled in by the	2	29a. Certifier 1 Certifying Physic	an: To the best of my knowled	lge, death occurr	ed at the time, date	e and place, and	due to the cause(s) and manner a	s stated.
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H × H 5	ž	29b. Signature and title of certifier		1	29c. License				(Month, Day, Year)
		CHARA	UnA		O.C.M	1.E.		May 1, 2011	
911		30. Name and address of person who			oltimers Ct	d Daltimore	MD 24222		
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11-03618 Kayla Smith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ayla Smith		State of Maryland 1- For State Registrar		ment of <i>icate of</i>		d Mental H	Re	eg. No.	11 1638		
Physicia <u>fle</u> dical Examir		1. Decedent's Name (First, Middle,Last) Kayla		Smit	h		2. Date of Deat Month May 13, 20	Day Year	3. Time of Death 2117 hrs		
		Facility Name (if not institution, give street and number) Calvert Memorial Hospital		4	b. City, Town, or Prince Fred	Location of Deat erick	h	4c. County of Calvert	Death		
Funeral Director		5. Social Security Number 6. Sex 7. Ag 1 M 2 X F 15	e (In yrs. last	birthday) Yrs.	If Under 1 Yea Months Day				9. Birthplace (State or Foreign Country) Mary land		
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location	on				10d. Inside City Limits		
	Ď	Maryland Calvert		Lus					1 Yes 2 No		
the Mary a or 28a tified at	Director	10e. Street and Number 12850 Abilene Trail			10f. Zip Code 20657		10	0g. Citizen of Wha	USA		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f she injury or other traumatic evect, the Medical Examiner must be confifed at once	Funeral			If Ye	es, specify Cubar	panic Origin? (S , Mexican, Puerto	American Indian, Black, etc. White				
ours after autural";	g p	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specity only highest grade con	pleted) 16	a. Decedent		ion (Give kind of DO NOT use rel		Specify: WNITE 16b. Kind of Business/Industry			
036 ithin 72 hane. ne. r than "na	Completed	Elementary/Secondary (0-12) College (1-4 or 9	ilred)	Educa	tion						
215-0036 be filed within 7 ntal Hygiene. rked other than	Be Co	17. Father's Name (First, Middle, Last) Michael Smith					e (First, Middle, N aret Rup	Maiden Surname) DP			
MD 21 d 2 should b dith and Mer m 27 is mar numatic eve	리	19a. Informant's Name/Relationship (Type, Print) Margaret Reyes/ Mother						nber, City or Town, Mar y land			
ore, M		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from Sta	ate cren	ce of Disposit	tion (Name of ce er place)	metery,	Date	20c. Location - C	ity or Town, State		
Baltimore, permit. Pages 1 ar Department of Hec Important: Utic Important: Utic Iminry or other tr		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Kal		ematory		19/11	Edgewat	neral Home		
	_	23a. Part I. Enter the disease, or complications that caused	the death De	29	73 Solo	mons Isl	and Rd.	Edgewate	r, MD 21037		
Physician Wedical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Air Embol	us	Thot enter the	e mode or dying,	suar as cardiac	or respiratory arre	sot, shoot, or reach	Between Onset and Death		
		or condition resulting in death) Due to (or as a consection of the condition of the condit	equence of):								
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease of It jury that initial ad									
cuted and transit		events resulting in death) Last Due to (or as a conse									
so, te be exe sysician a	Medical	UNPENDED AMENDED 23a IF FEMALE: 23c. If yes, outcore		_	r me,g9	15 5-24-	·11 sm	23d. Date of de	alivery		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physiciae: The law requires that the death certificate be executed within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	sician/	23b. Was decedent pregnant in the past 12 months?	time of death	2 Feta	al death 3	Ectopic pregn	ancy	Month	Day Year		
ires that the displaying signed by the detached	by Phy	Part II. Other significant conditions contributing to death	but not resul	Iting in the ur	nderlying cause o	jiven in Part I.			Ite to the cause of death?		
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Division To the Hospital or Attenct within 24 hours after death To the Fuoeral Director: completely filled in by the	ertific	4 Homicide determined (Specify) Sin			t, factory, office b reseider	-	28f. Location (S or Town, S Lusby, M	street and Number tate) 352 Wh	or Rural Route Number, City ite Sands Dr.		
Divi	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the best of mone)									
To cor	Me	29b. Signature and title of certifier			29c. Licens				(Month, Day, Year)		
		30. Name and address of person who completed cause of d	eath (Item 23a	a)	0.0.	VI.E.		May 15, 201	-		
		Carol Allan, MD Assistant Medical Exar	niner 900	0 W. Balti		Baltimore, N	1D 21223				
Sta Regista	ate	31. Date filed (Month, Day, Year) MAY 1 7 2011 32. Redistra	r's Signature	ha	Me						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16325 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 3. 2011 Hannah Schmidt 7:58 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3938 4th Street North Beach Calvert 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth **Funeral** Days 5 Months (Month, Day, Year) 4/29/2011 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Calvert North Beach 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3938 4th Street 20714 **USA** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry ມe filed who. **al Hygiene. *`ar than "r Elementary/Seconday (0-12) NA College (1-4 or 5+) NA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nick Schmidt Andrea Milanowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nick Schmidt - Father 3938 4th Street, North Beach, MD 20714 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 5/6/2011 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home Myslin T. Wlobas 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) dey Medical Due to (or as a consequence if) Examiner Sequentially list conditions, if any, leading to immediate

Cause (Disease or linjury Due to (or as a consequence of) ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica completed filled in by the funeral director, I of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၀ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending work? Division 2 No Investigation 6 Could not be Accident Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier dress of person who completed cause of death (Item 23a) (Type, Print) omes

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 sineath Day 2 Physician/ 15 P 6 Medical 4a. Facility Name (if not institution, give street and number)
CENESIS FLIENCE Park
24 Trucking Cane 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anno Arunde uerna Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Min. 1 M 2 XF 90 214-14-2190 Marvland Director Usual Residence of Decedent 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director Severna Park Anne Arundel 1 🗆 Yes 2 🔀 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21146 205 Balsam Drive Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc by 1 Never Married 2 Married 1 Yes 2 XNo White 1 Tes 2 No Specify: Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edith Noel Edgar A. McQuay permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Hila Rd.Millersville, MD 21108 19a. Informant's Name/Relationship (Type, Print) Joyce Timmons / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of May 07 2011 20c. Location - City or Town, State Moreland Memorial Park Cemetery 1 X Burial 2 Cremation 3 Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 495 Ritchie Hwy, 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ lucum disease or condition resulting in death) Medical Examiner lukuwun Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). eate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Calony Dr # Tidewater 31. Date filed (Month, Day, Year) MAY 0 5 2011 2. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

Amended item per physician		3e	Plea	se Type o								-		-	ble.	
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Physician/	1	I. Decedent's Name		_{Last)} lla Stahl								2. Date of D	Death	ay	Year	3. Time of Death
Medical Examiner		a. Facility Name (if i		-	mber)			4b. City		Location	of Death	05	05 4	c. County of		1910 ^M
Euroval	Dennett Road Manor 5. Social Security Number 6. Sex								Oakl er 1 Year_	and	r 24 Hrs.	8. Date of B		<u> </u>		L T
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leath with the Maryland tems 23a or 28a-f sh er must be notified at Funeral Director		2272 Sun		Road					21550)			lug. C	Citizen of W USA		try?
36 fter death , or item aminer m		Marital Status Never Marrie	_	12. Was Dec	orces?		13. V	Vas Dece Yes, spe	dent of H	ispanic Or ın, Mexica	rigin? (Spe in, Puerto	cify Yes or No Rican, etc.)	0-	14. Race Black	- Americ	
Baltimore, Maryland 21215-0036 Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Poparant: If team 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		3 Widowed 4	4 Divorced	If Yes, Gi Year or D	ve	NO .	1	☐ Yes	2 🗹 No	Specify	<i>:</i> :			Specify:	Wh	ite
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//anc		Ray Eva		ast)							ner's Name l ura	e (First, Middle Roth	e, Maidei	n Surname)		
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or Healt fitem 2	2	Dennis S Oa. Method of Disp	osition			20b. Pla	ce of Dispos	sition (Na	me of			Date		Location -		wn, State
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			t failure. List o	complications that nly one cause on e	caused ach line	the death.					_			6	1	Approximate Interval Between
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@ E E E		that initiated events resulting in death) L		Due to	(or as a	a consequer	nce of):									
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Records, The law require, sate has been si, page 2 should the	Ī											24a. Wa	ıs an	24b. W	ere autor	osy findings available
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No vith	2	9b. Signature and t	itle of certifier	ABO.	6.	1		29	c. License				29d. D	ate signed	(Month, L	Day, Year)
	3	0. Name and addre	ess of person v	vho completed cau	se of de	eath (Item 2	3a) (Type, P	rint)	<u>р</u> 64	302			19/	0 1	00	. (
State	3	1. Date filed (Month	n, Day, Year)	gham, M.I					h St	, Sui	te 1	00 . 0a	klan	d, MI	215	50
Registrar		MA	Y-62	011 2	bur	, A.	par	K								

Amended Item #26 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per physician 5/9/11 cs State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ D2 011 Month May 2, 10:12PM Richard Alen Suter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett Oakland Memorial Hospital Garrett Co. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min 1 X M 2 □ F Months Days Hours Maryland Director 218-62-6827 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Friendsville Garrett MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A. 21531 1296 Mill Run Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛛 No 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married 1 Yes : Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: ould be filed within 72 hours aft ind Mental Hygiene.

marked other than "natural". Specify: 3 Widowed 4 X Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction 12 Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First. Middle, Maiden Surname) ٥ Artice Beatrice Suter, Sr. Robert off. Page 1 and 2 shours out of Health and Mr. m 27 is m? 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1296 Mill Run RD. Friendsville, MD 21531 Theresa Suter/ Ex-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Sp Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department of Important: If any injury or Addison Cemetery 5/6/2011 Addison, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes P.A. 943 Second Ave., Friendsville, MD 21531 Mar 23a. Part 1. Enter the disease, or complications that vaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Year Pregnant at time of death 2 No the 9 Unknown g I Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulfing in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? certificate 1 Yes 2 No 25. Was case referred to medical examine? Hospital or Attending Physician: 26. Place of Death (Check only one) Be xaminer? Other: 4 Nursing Home 2 🗆 No 1 🗆 Inpatient 2 🗀 ER/Outpatient 3 🛣 DOA မ -6 ☐ Other (Specify within 24 hours after death. To the Funeral Director; After this funeral (27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending Division 1 ☐ Yes 2 ☐ No filled in by the Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the ! Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

A2. Registrar's Signature

311 N Fourth St., OAkland, MD 21550

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Johnson

MAY - 5 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month_ LEE STIERS ANDRA 9:00 AM Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Qeath 26:20 Cecil VA Many band Health System Point Social Security Number If Under 1 Year If Under 24 Hrs Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 😾 F (Month, Day, Year) Months Days Hours Bermuda 215-70-1412 **Director** 53 Usual Residence of Decedent shov 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified Maryland Cecil. **Elkton** 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2375 Old Field Point Road 21921 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' 1 Yes 2 No
If Yes, Give 1980-82 Black, White, etc. Completed by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify 3 Widowed 4 Divorced White any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Janitorial Maintenance Custodian Twelve Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Richard Baker Lorraine Storey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie Gericke (sister) 147 Rue Martine, Destin, Florida Baltimore, 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State West Chester, R.A.Ferris & Co., Inc. 1 Burial 2X Cremation 3 Removal from State 05/10/11 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 21. Signature of Funeral Service Licer ²² Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) unoidas. Medical Examiner Sequentially list conditions. Examine than, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last burial-transi Mellita setes Due to (or as a consequence of). attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☒ No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Hepatitis Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law 2 No 1 Yes ☐ Yes 25. Was case referred to medical Be 26. Place of Deat eck only one) 1 Yes Other: ည 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After to ompleted filled in by the funeral 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3+1VA Perry Paint Mid. VAMarland 31. Date filed (Month, Day 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

CANARA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** Elberta Todd Stevens 1228 8. May 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Harford Harford Memorial Hospital Havre de Grace If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours 1 □ M 2 🔀 F Months 218-32-6723 76 1934 Director May 18. Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Director 1 ☐ Yes 2 ☐ No Maryland Cecil Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 71 Hawthorn Drive, Box 93 21904 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc iled within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Completed by White 3 Widowed 4 Divorced 16b. Kind of Business/Industry Aberdeen Proving Ground 16a. Decedent's Usual Occupation event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene, Aberdeen, Maryland Twelve Years Secretary marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marvland Be t be t and Mental Marguerite Allabaugh Elbert Todd 2 Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 71 Hawthorn Drive, Box 93, Port Deposit, MD 21904 of Health (husband) Edward J. Stevens item 27 other to Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Important: If any Injury or once. 4 □ Donation 5 □ Other (Specify) Asbury Cemetery 05/13/11 Port Deposit, Maryland 22. Name and Address of Facility Signature of Funeral Service License Lee A. Patterson & Son Funeral Home, Perryville, Maryland 21903-0766 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical quence of): Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner requires that the death certificate be executed 00 UM the burial-trai resulting in death) Last Due to (or as a consequence of): for use as IF FEMALE 23c. If yes, outcome of pregnancy 23h. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) o. etached 9 Unknown þ ٦ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. been signer should be Completed by 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? a 24a. Was an has page 2 autopsy perform Vital wen 1 ☐Yes 2 ☐ No 00 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 4 1 4mpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 4 Natural 1 ☐ Yes 2 □No 2 ☐ Accident the 1 after death 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and majner stated. the 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 29c. License number cause of death (Item 23a) (Type, 30. Name and address

State Registrar 31. Date filed (Month. Day.

S

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Calvin Lee Stith, Sr. 01:00 A.M 2011 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince Georges Southern Maryland Hospital Center Clinton 5. Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** June 8. 1 X M 2 - F Hours 577-62-4755 63 Virginia **Director** 1947 Usual Residence of Decedent 28a-f show must be notified at 10c, City, Town or Location 10d. Inside City Limits Fort Washington 1 X Yes 2 No Maryland Prince Georges Ξ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20744 6801 Bock Road; Apt. 227 United States ural", or items ? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 **Black** If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Prince Georges County other than Elementary/Seconday (0-12) College (1-4 or 5+) years High School Teacher Public Schools Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Stith **Blunt** Otis Howard Gussie Lee 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Wanda Denise Overstreet-Stith 6801 Bock Road; Apt. 227; Fort Washington, Maryland item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o May 16,2011 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Special Riverdale Park Crematory Riverdale, Maryland Signature of Funeral Service 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between mmediate Cause (Final Physician/ disease or condition Medical resulting in death) FAILURG Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury and I-transit Exami death certificate be executed that initiated events resulting in death) Last sician a burial-1 Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year Yes 2 No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed? Yes 2 No or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Minpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 24 hours after death. Funeral Director: At 1 Yes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ompleted filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) the Hospital Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 1 (Item 23a) (Type, Print) CA LINE State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DayZoll Physician/ Month rancis 9100 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Prince George's Future Care Pineview Nursing Home Clinton 5. Social Security Number 6. Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours 213-78-9705 1960 Washington, DC Director 50 Aug Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 28a-f Prince George's Landover 1 X Yes 2 No MD 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 6401 Country Club Court 20785 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ö þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Lawn Care Provider 12th Private Be be filed \ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 0 Joseph M. Spenard Elizabeth Simmons permit. Page 1 and 2 should be Department of Health and Meni Important; if item 27 is marke any injury or other traumatic. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph M. Spenard/ Father 4663 Red Hawk Terrace, Bladensburg, MD 20710 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Riverdale Crematory 5/9/11 Riverdale, Maryland 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licenses 7474 Landover Road, Landover, Maryland 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Anoxic Physician Ence disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner reprovasculu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events pertension and I-trar Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Unknown ed by the a g Unknown signed by 1 d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ theknee amoutation decalities 1 Yes 2 No 3 Probably 4 Unknown Completed Mellitus Whates 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Chec Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sign 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year

82

32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 16393 State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY 5^{Day}2011 Physician/ JAMES SINGLETON, JR 6:35 A M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner MONTGOMERY BETHESDA NATIONAL NAVAL MEDICAL CENTER Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1 □**X**M 2 □ F 251-72-8971 68 South Carolina Director February 22. Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State should be filed within 72 hours after death with the Maryland Director Prince George's District Heights 1 X Yes 2 ☐ No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20747 2107 Harwood Road U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 XNo 1 Never Married 2 X Married ò Baltimore, Maryland 21215-0036 African American 1 ☐ Yes 2 X No Specify: If Yes, Give "natural" Completed 3 Divorced 4 Divorced Year or Dates mit. Page 1 and 2 should be filed within 72 hours artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natuinjury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Cement Meson Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ James Singleton, Sr. Annie Bell Roach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Theresa W. Singleton-Spouse 2107 Harwood Rd., District Heights, Maryland 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🗶 Burial 2 🗌 Cremation 3 🗀 Removal from State May 12, 2011 Cheltenham, Maryland Md Veterans Cerretery 4 Donation 5 Other (Specify) permit. Der artn Imports any inju 22. Name and Address of Facility Signature of Funeral Service Licenses Bonnette & Assoc. Funeral Home 2504 28th St., N.E., WDC a. Part Venter the disease, or complications. If at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) LUNG CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that the death certificate be executed Cause (Disease or iinjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Dav Year 5 Other (specify) Pregnant at time of death been signed by the a should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician: The law requires the within 24 hours after death.

Within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 12 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 Tes 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier 0101246064 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER MD 20889-5600 MC USN BETHESDA MCINTYRE PETER 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1. Decedent's Name (First, Middle, Last) William Harrison Sandrus, Jr. 4a. Facility Name (if not institution, give street and number) Prince George's Hospital Center Funeral Director 5. Social Security Number 219-42-4550 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 4b. City, Town, or Location of Death Cheverly 4b. City, Town, or Location of Death Cheverly 15. Months April 1 Under 1 Year Months Months 10c. City, Town or Location	2. Date of Dear Month May 6 Ma	, 2011 4c. County of Dec Prince	3. Time of Death 8:02 PM ath George's inthplace (State or Foreign ountry) shington, DC
Medical Examiner San	8. Date of Birth (Month, Day, March I.	4c. County of Dec	George's
Prince George's Hospital Center Cheverly 5. Social Security Number 219-42-4550 Cheverly 6. Sex 1 M 2 F 67 Yrs. Cheverly If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, March I.	Prince 9.B	George's
Director 219-42-4550 1 Months Days Hours Min.	(Month, Day, March 1	3, 1944 Wa	irthplace (State or Foreign ountry) shington, DC
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			
목 #경 [중]			10d. Inside City Limits
🙀 🖟 🛮 ပုံ Maryland Prince George's Riverdale			1 ☑ Yes 2 □ No
Maryland Prince George's Riverdale 10e. Street and Number 10e. Street and Number 10f. Zip Code 20737 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Cuban Mexican Puerton Prince) 14. Marital Status 15. County 10c. City, Town or Location Riverdale 10f. Zip Code 20737		10g. Citizen of What C	Country?
A Data and a Color of the Color	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
Second Se		16b. Kind of Business General S Administr	ervices
The state of the s	ne (First, Middle, M	Maiden Surname)	
The state of the s		-	
20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery) 20b. Place of Disposition	Date . / 2011	20c. Location - City o	
Gascii s runerar nom		Hyattsvil	imore Avenue 1e, MD 20781
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ATAL Due to (or as a consequence of):	or respiratory arre	est,	Approximate Interval Between Onset and Death
Examiner (Considering Heset FAI)	ure		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a sequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		-	
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Saturation of the state of the		bacco use contribute f	o the cause of death? Probably 4 Unknown
The continuity of the continui	24a. Was al autops perfori 1 Yes	sy prior to med? death?	utopsy findings available completion of cause of
The state of Death (Check examiner) 25. Was case referred to medical examiner? 26. Place of Death (Check examiner) 1 Yes 2 No 1 Inpatient 2 Revolution to 3 DOA Other: A Nursing No No Inpatient 3 DOA Other: A Nursing No Inpatient 3	k only one)	_	
The second of th		ence 6 Other (Spe	cify)
27. Manner of Death 27. Manner of Death 28a. Date of Injury 28b. Time of injury 28b. Time of injury at work? 28c. Injury at wo	28f. Location (St. City or Town	treet and Number or R n, State)	ural Route Number,
27. Manner of Death 28a. Date of injury 28b. Time of injury at work? 28c. Injury at	it the time, date an	nd place, and due to the	cause(s) and manner stated.
29b. Signature and five of certifier 29c. License number Di34.88		29d. Date signed (Mon	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLIFFIN DAVIS NO 3001 HOSPITM DLIVE CHEVERLY, I	mo 20	785	, - 0
State Registrar State Registrar			

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene ~ For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY Physician/ 1007 AM 2011 Shindledecker Guy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Hagerstown Meritus Medical Center If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 08 12 1 🜠 M 2 🗆 F Months 1942 Waynesboro, PA 172-32-0187 68 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Hagerstown MD 1 🗆 Yes 2 🔀 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o Funeral hours after death with 21742 US 13818 Long Ridge Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give Specify 3 Widowed 4 Divorced Completed Year or Dates er than "natur ; the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. product manager marketing permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If Item 27 is marked other 1 any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Melvin L. Shindledecker Rachel June Shank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13818 Long Ridge Dr. Sally Shindledecker/spouse Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 X Removal from State May 17, 2011 Waynesboro, PA Green Hill Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc Waynesboro, amer Broad St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) DRONARY Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? jo Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 ☐ No the 9 Unknown detached 9 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by within 24 hours after death.

To the Funeral Director: After this certificate has been signs completed filled in by the funeral director, page 2 should be a 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ER/Outpatient 3 DOA မ 1 Inpatient 2 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28h Time of 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) 5 Pending 1 🗌 Yes 2 🔲 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical i 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 29c. License numbe クションブ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11113 31. Date filed (Month) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARIE Physician/ THELMA SYDNOR мАЧth 17,2011 9:41P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CHARLES 2625 FERGUSON COURT WALDORF If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours 1 M 2 XF Month, Day, Year) 18 219-01-8931 92 MD • **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director CHARLES WALDORF MD. 1 🗌 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20602 2625 FERGUSON COURT U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 her than "natural", (,, the Medical Exam Specify: WHITE 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) INSURANCE CO. OFFICE MANAGER 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MILDRED ELIZABETH MOLESWORTH JAMES PATTON MURPHY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2623 FERGUSON CT. WALDORF, MD. 20602 DIANA WINES-DAUGHTER 20a. Method of Disposition

1
Burial 2 Cremation 3 Removal from State Cemetery, cremate NET ROPOLITAN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date CREMATORY 5-19-11 ALEX., VA. M00479 Signature of Fureral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the anderlying dause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 s autopsy performed? 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificated filled in by the funeral director; I Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Nesidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate Natural Accider Suicide work? 1 ☐ Yes 2 ☐ No 5 Pending NIA M Accident Investigation 6 Could not be within 24 hours after de
To the Funeral Directo
completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signa 29d. Date signed (Manth, Day, Year) P 34 s of person who completed cause of death (Item 23a) (Type, Print) Rd., Ste. 100, WAldorf, ND 20100\$

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20 Î Î May 5:43 Spessard AMJohn Ervin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Broadmore Senior Living at Hagerstown Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov • 24, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 920 1 X M 2 □ F Days Hours Min Director 187-16-5935 Nov. Pennsylvania Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🕅 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1175 Professional Court 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
77 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Service Representative Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John B. Spessard Lela Maude Downin Jean 12 st.
Jepartment of Health an.
Important: If item 27 is n
any injury or other trangonee. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald E. West/Step Son 121 Southern Oak Drive, Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 5/19/2011 Hagerstown, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rest Haven Funeral Chapel S. Mark Su 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one c Interval Between Immediate Cause (Final Onset and Death Physician/ GANGRENE disease or condition resulting in death) CEFT CREAT TOE FRWDAYS Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate

Finer Underlying

Cause (Disease or linjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ WYPER KIPIDEMIK MIPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed ALZHRUMERIS DISEASE «LAVESMA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 perform Yes 2 AN 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) funeral Certificate: 28b. Time of 28c. Injury at I Director: After to in by the funeral 28d. Describe how injury occurred Natural 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

9

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Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

VASANT DATTA

-catt mg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

~ 0

340

32. Registrar's Signature

29c. License number

D18019

MAKERSTOWN

29d. Date signed (Month, Day, Year)

WAT 16, 2011

MO 21740

11-00101

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Janet Snyder		1- For State Registrar		tate of Maryla		epartmen Certificate			Menta	al Hy		Reg. No.	20	Manage Control	1639
Physician Medical Examino		Decedent's Name		_{le,Last)} Elaine Sr	nyder					2	2. Date of Dea Month January 3	Day	Year		Time of Death
		4a. Facility Name (1 125 W. Hilc		on, give street and no	-	·	41	D. City, Town, or Li Hagerstown	ocation of	Death	oundary (4c.	County of De		
Funeral Director	- 1	5. Social Security N 216-54-81	.63	6. Sex	7. Age (In	yrs. last birthda	y) Yrs.	If Under 1 Year Months Days	If Under Hours	24Hrs. Min.	8. Date of B		1949 For	Birthpla reign Count	ace (State or Byry land
y any	-	Usual Residence of 10a. State	10b. County		10c.	City, Town or L			·						d. Inside City Limits
Aaryland 28a-f show	ខ្ញុ	Md. 10e. Street and Nur		shington			lage	erstown 10f. Zip Code				10. 0::-			X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once	ar Ulrector	25 W.		rest Rd.				21742				10g. Citizen of What Country? U.S.A			
er death w , or items	by runeral	11. Marital Status 1 Never Marrie 3 Widowed	4 Div	arried 12. Was Dec Armed F 1 Yes rorced If Yes, Give Yes or Dates:	orces? 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	No 1	If Ye	s Decedent of Hispanic Origin? (Specify Yes or es, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 No specify: t's Usual Occupation (Give kind of work done			ican, etc.)	White, etc.		Whit	ce
5-0036 led within 72 hour Hygiene. other than "natu	inpieted	Elementary/Seco	ndary (0-12)	cify only highest grade College (*		16a. Dec	ng mos	st of working life. D SSEMbly	DO NOT u	se retire	d)		ind of Busine Manufa		•
21215-0036 Auld be filed within 7 Mental Hygiene. marked other than e event, the Medica	ů n		Leste	er Snyder					В	etty		Hun ⁻	tzberr		
ages 1 and 2 should nt of Health and M tt. If item 27 is m other traumatic			Kline	hip (Type, Print) e (Sister)		301	L Rá	Address (Street and Cliffe	Ave.	Hag	gersto	√n,M∈	d.2174	0	
imore Pages 1 ment of F tant: If		20a. Method of Disp 1 Burial 2 4 Donation 5	Cremation Other Sa			crematory of	or othe	on (Name of ceme or place) Memoria Park me and Address o		Jan. 201		Wi	ocation - City 11i ams	or Tow port	n, State , Md .
	1	21. Signature of Fur	Javis Mo1414 J.L. Davis Funeral HomeSmithsburg, Md. 21783										/ Ave. 21783		
Physician /Medical Examiner	1	failure. List onl Immediate Cause (F	y one cause Final disease	on each line.				mode of dying, su vascular Dise		diac or r	espiratory arr	rest, shoo	ck, or heart		pproximate Interval etween Onset and Death
May of the same of	١	or condition resulting Sequentially list cor		Due to (or as a	consequen	ce of):									
red Framine		if any, leading to im cause. Enter Under (Disease or injury th	rlying Cause nat initiated	c. Due to (or as a											
O, sician and burial - transit		events resulting in o	death) Last	d							<u>-</u> -			_	
60, ate be execute hysician and e burial - tran		UNPENDED		X AMENDED	4a,pe	rME,G91	5,5	3/20/2011	.,WS			1004	Data of Halling		
). Box 6876(the death certificate by the attending physiched for use as the b Physician/Me	2	3b. Was decedent p past 12 months		e 1 Live b		2			Ectopic p	regnand	_Б у		Date of deliv Month	Day	Year
1.0. Box		1 Yes 2 N		9 Unkno				(Specify)							
ires that the signed by the detach	2	Lupus Eryth			death but r	not resulting in t	ne und	derlying cause give	en in Part	i.					cause of death?
Division of Vital Records, P.O. Box 6876 To the Bospital or Attending Physician: The law requires hat the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the ledical Certification: To Be Completed by Physician/M.	n bick						-	·		-		osy rm <u>ed</u> ?	prior t death	o comp ?	y findings available letion of cause of
n of Vital Reco		25. Was case referre	ed to medical					26.Place of		heck onl		2 ✓ No	1	Yes	2 No
of Vit ing Physic After this uneral dire	2 -	1 ✓ Yes 2 27. Manner of Death		Hospital: 1 1 1	npatient 2 of Injury	ER/Outpat 28b. Time					Home 5		ce 6 🗸 Otl	ner: Sce	ene
tending tending death. tor: Af		1 Natural 2 Accident	5 Pend	(Month,	Dey Year)		,		s 2 N		Su. Bookingo	now injur	y coodinou		
Comparative for the part of th									oute Number, City						
Di To the Hospital within 24 hours: To the Funeral completely filled		29a. Certifier 1 (Check only 1 one) 2	Certifying Ph Wedical Exar	nysician: To the bes niner: On the basis of and manner si	of examination	vledge, death or on and/or invest	ccurre tigation	d at the time, date n, in my opinion, d	and place eath occur	e, and du	ue to the caus ne time, date	se(s) and and plac	manner as si e, and due to	ated. the cau	use(s)
		29b. Signature and t	itle of certifier					29c. License r O.C.M.		-			ate signed (A		Day, Year)
3	3	0. Name and addre		who completed caus			altim	ore Street. Ba	altimore	. MD 2	21223			_	
State Registra	_	1. Date filed (Month	Day Year)		gistrar's Sig										
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	•	For State Registrar		State of Ma	•	Certificat			u Wenta		g. No.	The second secon	16399	
Physicia		1. Decedent's Name (File Frank	rst, Middle, Las	,	hiripa				2. Date Mor Ma		Day	Year 2011	3. Time of Death 10:10P M	
/Medic Examine		4a. Facility Name (If not	_					Location of D			4c. Count	y of Death Mary	's	
Funeral Director		5. Social Security Numb 116-14-5032	er 6. Se		(In yrs. last birt		1 Year			of Birth oth, Day, r 30,	1	9. Birthp	lace (State or Foreign try) W York	
yiand how		Usual Residence of Dec 10a. State 10t	b. County		10c. City, Town	or Location						1	Od. Inside City Limits	
he Ma	ector	MD	St. Mai	ry's	Cl	narlotte		.1		10	0:::		1 ☐ Yes 2X No	
3a or 3	i Di	10e. Street and Number 29449 Cha		Hall Road		10f. Zip		0622		10	g. Citizen of U	what Cour SA	ury ?	
urs a	by Funeral Director	11. Marital Status 1 ☐ Never Married 3 🛣 Widowed 4 ☐		12. Was Decedent E Armed Forces? 12 Yes 2 N If Yes, Give Year or Dates:		13. Was Dece If Yes, spe		spanic Origin n, Mexican, P Specify:	? (Specify Ye Puerto Rican, e	s or No- etc.)		ce - Americ ick, White, fy: W		
within 72 ho liene. r than "natur	Completed	15. (Specify of Elementary/Secondar 11	Decedent's Ed nfy highest grad y (0-12)	ucation de <i>completed)</i> College (1-4or 5-		Decedent's Usu (Give kind of wo life. DO NOT u	se retired)	f working	1	6b. Kind of E	Business/Ind		
y idnity and be filed Mental Hyginarked other atic event, I	To Be C	17. Father's Name (First Cosimo Sch							Name (First,			iden Sumame) 1a		
2 shou and M is ma raumat		19a. Informant's Name/			19b.	Mailing Address	(Street a	and Number o	or Rural Route	Number,	City or Town	tity or Town, State, Zip Code)		
Health Health tom 27 other tre	1	Kathleen Hall/Daughter 9615 Oriole Lane Bel Alton MD 20611 20a. Method of Disposition										wn, State		
Peges nent of ant: If i		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 State 4 Donation 5 Other (Specify) 1 Charlotte Hall,										a11,MD		
permit. Peges 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funera	I Service Licen	Eha 20	yb45				FUNERA Ave. L		-	206	46	
Physician /Medical Examiner	Examiner	23a. Part1. Enter the di shock, or heart fai Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition if any, leading to immedicause. Enter Undertyin Cause (Disease or injur that initiated events resulting in death) Last	lure. List only o	a. Due to (or as a b. Due to (or as a c.	consequence of	Hen		_ 1	15.00				Approximate Interval Between Onset and Death	
ificate be g physicie as the bur	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 1 Unknown 1									23d. Date of delivery Month Day Year			
uires thet signed b	۾	Part II. Other significan	t conditions co	ontributing to death bu	t not resulting in	the underlying	ause give	en in Part I.	23		acco use cor		ne cause of death?	
n: The law req icete hes beer r, page 2 shou	Completed								_	a. Was an autopsy perform Yes 2		prior to co death?	psy findings available mpletion of cause of 2 No	
yelciar s certif directo	o Be	25. Was case referred t examiner? 1 ☐ Yes 2 ☐ No		Hospital: 1 ☐ Inpatier	nt 2 ER/Out	patient 3 D	Othe	_	Death (Checong Home 5			her (Specif	v)	
ing Ph Mier th	Du: T	27. Manner of Death 1 Natural 5	☐ Pending	28a. Date of Injur (Month, Day	y Year) 28b. T	ime of	28c. Injury Work	at	28d. De		w injury occu			
To the Hospitel or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2.	Certification:	2 Accident 3 Suicide 6 4 Homicide	investigation Could not be determined		ry - At home, far . (Specify)	m, street, factor		Yes 2 □ No	28f. Loc	eation (Strey or Town,	eet and Num State)	ber or Rura	il Route Number,	
Hospi 24 hour Funer etely fills	edicai	29a. Certifier 1 (Check only one)	Certifying Phy Medical Exam	ysician: To the best o niner: On the basis of and manner stat	examination and	, death occurred Vor investigation	at the tim	ne, date and pointion, death	place, and due occurred at th	to the car e time, da	use(s) and m te and place	anner as s , and due to	tated. the cause(s)	
To the within To the comple	Mec		of catifier		<u> </u>	29	c. License	number	70	29	d. Date sign	ed (Month,	Day, Year)	
10 (1)		30. Name and addless	of person who	completed cause of de	eath (Item 23a) (Type, Print)	7	117	10	01:	D- 5	1	~	
B57 Stat	e	31. Date filed (Month, D	Pay, Year)	32. Rygistra	r's Signature	220	10	14	My	9110	5 K	N N	20769	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Edna Doreen Thompson 2011 4 m q May :55 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Frederick Calvert Prince Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 💢 F (Month, Day, Year) 9 / 2 1 / 1 9 3 0 577-38-9026 Months Hours Min. 80 Director Usual Residence of Decedent fshow 10a. State 10b. County event, the Medical Examiner must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 23a or 28a-1 MD Prince Georges Brandywine 1 X Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10505 Cedarville Rd. Lot 1-2 20613 USA items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 ☐ Yes 2 💢 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert W. Walker Martha Alice Sisk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other tratonce. Robin Campbell/Daughter 3606 King Drive, Dunkirk, MD 20754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/10/11 Suitland, MD Wash. Cem. 21. Signature of Funeral Service I censee 22. Name and Address of Facility Raymond-Wood F.H., P.A. PO Box 430, Dunkirk, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available this certificate has page 2 autopsy perform prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to paedical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hince Frederick MS 20678 Harshinder Sidhu, MD 100 Hospital

State Registrar 32. Registra's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7 Per FH C916 6 13/2011 Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Melvin Hillard Tephabock 201 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Cumberland Western Md Health Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months (Month, Day, 1 X M 2 D F 90 Director WV 232-26-1931 Usual Residence of Decedent shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director 28a-f 1 🗌 Yes 2 🕱 No Elk Garden WV Mineral 10f. Zip Code 6 10e. Street and Number 10g. Citizen of What Country? USA items 23a Funeral 26717 RT 1 Box 163 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black. White, etc. 6 ☐ Yes 2 No Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White "natural" 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. Elementary/Seconday (0-12) College (1-4 or 5+) farming farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) စ္ Richama Susan Westfall William Leonard Tephabock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26717 RT 1 Box 162, Elk Garden, WV Lane Tephabock-son Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ■ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) Elk Garden, WV 5/11/2011 I.O.O.F Cemetery 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service License 22. Name and Address of Facility David A. Burdock Funeral Home PA N. 2nd St, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant. 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 mont 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death g Unknown Month Day Year 1 Yes 2 9 Unknown as been signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy perform death? 2 🗌 No 1 🗌 Yes 1 Yes 25. Was case referred to medica To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 1100 မ 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No Accident Investigation ☐ Accide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. natur ress of person who completed cause of death (Item 23a) Type, State 9 Registrar

			For	State of Ma	arylan	d / Depa	artmen	t of He	ealth an	nd M	ental Hyg	giene				
			State Registrar			Cer	tificate	of De	eath			Reg. No	201	Michael	161	:02
	Physicia		1. Decedent's Name <i>(First, Middl</i> e, <i>La:</i> Harold	st) Eugene Tol	1eng	er					2. Date of Dea Month May	th Day	201	ear 1	3. Time of I	
\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \	Medic Examir		4a. Facility Name (If not institution, give		Lo	t 24		Town, or L	ocation of E	Death	Tiay		County of	Death	ford	
	Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs. la	ast birthday)	If Under	1 Year	lf Under 24	Hrs.	8. Date of Birth	h Vacal	g	. Birthpl	ace (State or	Foreign
	Director		215-86-8327 1 Usual Residence of Decedent	X M 2 □ F	47	Yrs.	ivionins	Days	Hours	IVIII.	July 2	0^{rear}	.963	Ma	ryland	
	aryland la-f shov rfied at	ector	10a. State 10b. County Maryland Har:	ford	10c. City	y, Town or Loc		rdeen						10	d. Inside City	
:	ith the M 23a or 28 st be not	Funeral Director	10e. Street and Number 1121 Old Philade	Lphia Road	Lot	24	10f. Zip	Code 210	01			10g. Cit	izen of Wha			
99	should be filed within 72 hours after death with the Maryland that Maryland Hydiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	ğ	11. Marital Status 1 ☒ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X If Yes, Give	ver in U.S	3. 13. V	Yes, spec	ify Cuban,	Mexican, P		ify Yes or No- ican, etc.)		14. Race - A	America White, et	tc.	
Maryland 21215-0036	"natural	Completed	3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gr	Year or Dates.	1 ☐ Yes 2 ☑ No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working					16b. Kind of Business I			ess Indi	ite ustry		
2121	ygiene. her than nt, the M	Be Com	Elementary/Seconday (0-12) Eleven Years	College (1-4 or 5	+)		Laboi	rer				Port	Depo		, Mary	land
/land	d be med Mental H arked ot atic ever	To B	17. Father's Name (First, Middle, Last) Harold N	1. Tollenge	Collenger 18. Mother's Nan					(First, Middle, I Lrginia			er			
			19a. Informant's Name/Relationship (7) Alvin G. Bailey	ype, Print)		19b. Mailin 1121	g Address 01d l	(Street and Phila	d Number o delph:	r Rural ia E	Route Number, Rd., Lo	t 24	Town, State I , Ab 6	, zip Co erde	en, MI 2100	
mo	- '= = 0		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia			lace of Disposemetery, crem			Inc. 0		ate 2/11	.20c. Lc West	Ches Penns			
Balt	permit. Page Department of Important; If any injury or once.		21. Signature of Funeral Service Licent	000 F NO	n 5	22	Nama and	A Addross	of Engility		Son Fun	nera	1 Hom	e, 1	S.A.	
n			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final	plications that caused ne cause on each line	the death										Approximate Interval Betw Onset and D	veen
	Medical Examiner		disease or condition resulting in death)	a. Due to (or a la	consequ	ence of):	n							+		
7	- #s	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	ence out.											
'60 ate he everuted	ician and	al Examin	Cause (Disease or iinjury that initiated events c. Due to (or as a consequence of):								+					
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BOX 68	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live Birth : 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal	I death 3	Ectopic p Other (spe					Į.	23d. Date o Month		•	ear
J. Hard	igned by	þ	Part II. Other significant conditions of	ontributing to death bu	ut not resu	ulting in the ur	nderlying c	ause given	in Part I.						cause of de	
VITAL RECORDS,	s been s	Completed						<u> </u>		_	1 🗆 Y	ın	24b. Wer	e autops	ably 4 🗆 U	vailable
Yec	icate ha										autop: perfor 1 Yes	med?	deat	to com th? Yes 2	pletion of ca ☑ No	use of
[2]	certif	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:				Othor	e of Death (0				_			
N OT V	n. After this funeral di	ate: To	27. Manner of Death	28a. Date of injur (Month, Day,	у	ER/Outpatient 28b. Time of injury	28	Bc. Injury at work?		28	e 5X Reside			pecify)		
DIVISION OT	after deat Director: in by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined		ry - At hor . (Specify)	me, farm, stre	M et, factory,		S Z LINO	-	28f. Location (Street and Number or Rural Route Number, City or Town, State)				er,	
Hospital	4 hours Funeral l	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Exami	sician: To the best of r	my knowle	edge, death o	ccured at t	the time, da	ate and place death occur	ce, and	due to the cau	se(s) and	d manner as	s stated	se(s) and man	ner stated.
T the	within 2 To the comple	Ĭ	only one) 3 Certifying Nurs	se Practioner: To the b	oest of my	knowledge, d	eath occur	ed at the ti	me, date an	d place,	and due to the	cause(s	and manne e signed (M	r as stat	ed.	
			b b	n				1005	502	6		5	16/	11		
	4		30. Name and address of person who of Stephen C. Naylo					Road,	Cono	win	go, Mai	ryla	nd 2	1918	3	
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	r's Signati	ure	ak	/								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5/372011 5:53 P Laura Louise Thaxton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Vorcester Atlantic General Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign OH Country) 1 □ M 2XX F Hours Min. 1/971946^{Year)} Director 315-46-6673 Usual Residence of Decedent per itt. Page 1 and 2 should be filed within 72 hours after death with the Maryland Deg artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at one. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Berlin MD Worcester 1 Yes 2 ☐ No 10g. Citizen of What Country? 10f. Zip Code by Funeral 21811 3 Mast Court 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14, Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes X No DOG: 1/4/46 DOD: 5/3/11 Beltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes XX No Specify: If Yes, Give 3€XWidowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) hairdresser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Campbell Samuel Seifer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rich Thaxton (son) 116 Carneliard Court Pikesville, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State cemetery, crematory or other place) First State Crematory:5/6/2011 Millsboro DE 4 Donation 5 Other (Specify) 21. Signature of Fur eral S 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the ituneral director, page 2 should be detached for use as the burial-transit attending physician and for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MID 05/04/2011 D006 4120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGH 9733 Health Way Drive Berlin M.D Zeeshan State 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rita Caroline May 1,2011 Washington 0915 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Washington Rockville Montgomery Social Security Number 063-20-8676 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 96 New York Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Rockville 1X Yes 2 ☐ No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertal Hygiene. Important: I fem 27 is amerked other than "natural", or items 23a or important: I fem 27 is amerked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be. Funeral 6105 Montrose Road 20852 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3

Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Philip Kling Margaret Mundy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Mode) 20852 Barbara Gownder/Daughter 12401 Village Square Terrace #301 Rockville, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Chesapeake Crem. 5/02/2011 4 Donation 5 Dother (Speoff) Beltsville, Md PHTTTPADERTNALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami tansi To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a, Was an cate has t page 2 sl autopsy certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After thi
Completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniury 1 Yes 2 🗆 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5/2/2011 hin D0064871 Farel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 Montrose Rd Rockville 2035- 2 MD Fazli 31. Date filed (Month, Day, Year)

MAY 0 5 2011 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1820 Jeannine Celeste Wingire 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Rehabilitation and Nussing Center Sandy Spring lontgomen Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 - M 2 - YF 144-34-3114 1942 New Jersey September 14, **Director** Usual Residence of Decedent Strout by the state of the stat 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 4 1 Silver Spring 1 Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13733 Ivvwood Lane 20904 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married Completed by 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: White Year or Dates any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NIH Procurement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Michael Joseph Triolo Genevieve Cappetta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicole C. Wingire-Daughter 13733 Ivywood Lane, Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State cemetery, crematory or other place 1 Durial 2 X Cremation 3 Removal from State Baltimore Washington Crem: May 6, 2011 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland 22. Name and Address of Facility
Fleck Funeral Home, Inc.
7601 Sandy Spring Rd, Laurel, Maryland 20707 21. Signature of Funeral prvice Licensee M01234 23a. Part 1. Enter the diselse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ Vaginal carcinoma with metastases disease or condition ears Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examin sician and burial-transit requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 1 ☐ Yes 2 🗷 No 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No the Hospital or Attending Physician: The 2 🗌 No 1 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: 1 Tes ၉ 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 124 hours after death.

e Funeral Director: After pleted filled in by the fun 5 Pending 2 No 1 Yes Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 6 W1516120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 18100 State School Food Sandy Brooke State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Winifred W. Wheeler Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tizens Nursing Harfore Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs. **Funeral** 1 ☐ M 2**½**☐ F Months Hours Min 220-12-8280 88 Yrs **Director** 2/06/1922 Maryland Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No MD Harford Havre de Grace 10f. Zip Code ò 10e. Street and Numbe 10g. Citizen of What Country? items 23a or ner must be i Funeral Martin Road 21078 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Force Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify White Specify: "natural" 3XXWidowed 4 □ Divorced Completed th and Mental Hygiene.

77 is marked other than "natur traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Government Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ဂ္ John Ward Dora Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randolph Wheeler (Nephew) 807 Martin Road, Havre de Grace, Maryland 21078 20a. Method of Disposition
1 Å Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 05/13/2011 | Rising Sun, Maryland 22. Name and Address of Facility Zellman Funeral Home, P.A. Washington St., Havre de Grace. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ GA Medical resulting in death) equence of) Examiner Facuum fielly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last and the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 mg ģ Month Day Year Pregnant at time of death detached g 🗆 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed Completed by page 2 should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖭 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? this certificate 2 💾 No Yes 2 Division of Vital completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 I Nursing Home 5 Residence 6 Other (Specify) 27. Manufer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation after death Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 2

Registrar DHMH 17 Rev 7/2009

State

Name and address of

ChIN

M116

10/11

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#/perFH, G916, 6/1/2011, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY Month Physician/ 2011WILLIS 2137 TSTAH Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince Georges Ft. Washington Ft. Washington Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) Age (In yrs. last birthday, Funeral 1 🕱 M 2 🗆 F July 7, 1928 SC **Director** 249-34-3440 82 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2X No Prince Georges Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20744 208 Bonhill Dr. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married X Yes 2 No Baltimore, Maryland 21215-0036 Year or Dates. 1945 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Widowed 4 Divorced Black Completed th and Mental Hygiene. 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 9th College (1-4 or 5+) Central Bus Co., INc. Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Eva Belton unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Ft. Washington, DC 20744 208 Bonhill Dr. Najuma Sissoko -Daughter injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Cremator∳ 5-6-2011 Alexandria, VA Signature of Funeral Service Licensee Marshall March Funeral Home of Maryland JE S Suitland, MD. 20746 4308 Suitland Rd 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Bladder Onset and Death Immediate Cause (Final etastatic ancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Day in the past 12 months? Month Year Pregnant at time of death 2 No certificate has been signed by the irector, page 2 should be detached 9 Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ension 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 X ER/Outpatient 3 I DOA 1 Yes 은 this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural After 5 Pending injury 1 Yes 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 2011 MD AVI completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who eepak Dachdeva M.D. 11711 Livingston Rd Fort Washington, MD 20744 31. Date filed (Month, Day, 32. Registrar's Signature State 0 9 2011

ORIGINAL

Registrar

Division of Vital Records, P.O. Box 68760

		for State Registrar	State of Marylan		artment of I tificate of I			20	•	16408
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ling F	Certificate:	27. Manner of Death 1	8a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury w <u>or</u> k	?	28d. Describe ho	w injury occurred	1	
tend death tor: /	iji	2 Accident Investigation 3 Suicide 6 Could not be				Yes 2 No				
or All	<u>F</u>	4 Homicide determined	8e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stree	et, factory, office		28f. Location (Str City or Town	reet and Number , State)	or Rural Ro	ute Number,
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To the Hospital or Attending Ply within 24 hours after death. To the Funeral Director: After the completed filled in by the funeral	Medical	29a. Certifier 1 Certifying Physician (Check 2 Medical Examiner: Continuo Physician Check 2 Certifying	In the basis of examination	and/or investig	gation, in my opinic	n, death occurred a	at the time, date an	d place, and due t	to the cause	(s) and manner stated.
o the	— r	only one) 3 Certifying Nurse Pra 29b. Signature and title of certifier	ctioner: To the best or my	knowleage, ae	29c. License			cause(s) and mani 9d. Date signed (
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Ma	ł	30. Name and address of person who complete	eted cause of death (Item	23a) (Type Pri	D610	001		MAY 6,	2011	
77		FREDISA FRANCIS M.				AD #215 (COLUMBIA,	MARYLAN	D 210	044
Stat	е	31. Date filed (Month, Day, Year)	32/Registra s Signatu					· · · · · · · · · · · · · · · · · · ·		
Registra		AY 0 9 2011 Jenua	P. A ark							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 Year 2011 0745 Wolfe Ruth Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS-Regional Medical Center umberlana Allegani 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 □ ₹ Country) MD Months Director ^{Month}√^D28. 1928 213-24-5892 82 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 118 Seymour Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married þ 1 Tyes 2 No Specify. 3 XWidowed 4 Divorced Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Nancy (Hook) Brown William Brown 19a. Informant's Name/Relationship (Type, Print) Address (Street and Number or Rural Route Number, City or Town, State, Zip 917 Amherst Avenue Cumberland MD 21502 Shirley Wratchford 11917 Amherst Avenue daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Restlawn Memorial Gardens 5/18/2011 MD LaVale 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause /Final .Physician/ disease or condition resulting in death) archopulmon Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause ofdeath?

1 Yes 2 No 24a, Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural Accident 5 Pending injury Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

To the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After completed filled in by the funer

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or than "natural", or items 23a of the Medical Examiner must be

filed within 72 hours after death

permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me

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certificate

funeral director,

Medical

29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AB DI)1 HAWAN CHEEN 12500

should

Baltimore, Maryland 21215-0036

notified at

DHMH 17 Rev 7/2009

State Registrar Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DIANNA WHITE 3: 50 2011 MAY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 1 Hours **Director** Maryland 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits by Funeral Director must be notified 1 Yes 2 No SonVil 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? 216 or items Was Decedent Ever in U.S. . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. . Page 1 and 2 should be filed within 72 hours after carner of Health and Mental Hygiene. Fart if then 27 is marked other than "natural", or lury or other traumatic event, the Medical Examinius or other traumatic event, the Medical Examinius. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes Give Specify Specify: Completed 3 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) -00K Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brittingham Easton, MD, 21601 Angela 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Home, P. Funeral Henry Part 1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Physician/ MYOUARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner COPEMARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last and as the burial-trar Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy cate has been signed by the atter page 2 should be detached for in the past 12 months? Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director. 2 🗆 No 1 Yes Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) P25582 MAY 6 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNIVERSITY OF MARYHAD MEDICAL CENTER 22 SOUTH GREENS SUFFREDINI

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Dav. Year)

0 9 2011

Registrar's Signat

			Please	Type or Print in				-			
			For State	State of Maryla		Department of I Certificate of I					1 154 1 1
			Registrar 1. Decedent's Name (First, Middle, La	ast)		Octimente of I	Death	2. Date of De	Reg. No eath	<u> </u>	3. Time of Death
	Physicia Medi			LIP WAL	KER			Month S	06	y Year	8:45 PM
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	Funeral Director			Sex 7. Age (In yr		Yrs. If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.		th ly, Year)	9. Bir Co	thplace (State or Foreign wintry)
\$	yland f show	tor	10a. State 10b. County	10c.	1	or Location					10d. Inside City Limits
9	within 72 hours after death with the Marylan glene. er than "natural", or items 23a or 28a-f sh is the Medical Examiner must be notified a	Funeral Director	mb Dozch	ESTER	CAI	MBRIDGE 10f. Zip Code			10 09	tizen of What Co	1 Yes 2 No
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7	death ritem		11. Marital Status	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No	U.S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp	pecify Yes or No- o Rican, etc.)		14. Race - Ame Black, White	
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laryla	d Men d Men marke matic	-	JAMES 19a. Informant's Name/Relationship (COTHY		10mut	
X Ma	d 2 shoalth an 27 is		SUSAN T. WALK	" f' -	q^{196}	Mailing Address (Street					10 21613
Sore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3	201	o. Place of cemeter	Disposition (Name of y, crematory or other place	- 1	Date		ocation - City or	
Na.	nit. Page artment c ortant: If injury or		4 Donation 5 Other (Spec	ify) M	ID S	HORE CREMA		8 2011		nbride	
Ba	permit. Departr Imports any inju		21. Signature of Funeral Service Licer	Isee Park		22. Name and Addre	SS OF FACILITY SYY	XV SHOR Romwall	O.O.C	AMBRIDE	MD 21613
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289	eath certificate be a attending physicie d for use as the bur	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg	anancv				Т	201.01	
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 24 hours after death. To the Luneral Director, After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the but the properties of the properti	Physician/Medical	in the past 12 months? 1 Yes 2 No 9 Unknown		etal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	ру 			23d. Date of de Month	Day Year
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of Vi	Physi r this c gral dire	<u>۶</u> : ک	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatient 2 28a. Date of injury	28b. Ti	patient 3 DOA Other	4 L Nursing H	ome 5 Resid			ity) HOSPICE
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	he Hospit in 24 hour he Funera pleted filk	Medical	(Check 2 Medical Exam	vsician: To the best of my kno niner: On the basis of examina se Practioner: To the best of	tion and/or	investigation, in my opinio	on, death occurred a	at the time, date a	nd place,	and due to the	cause(s) and manner stated.
	Veith of the state		29b. Signature and title of certifier			29c. License			29d. Dat	e signed (Month	n, Day, Year)
	1/		30. Name and address of person who	completed cause of death (It	em 23a) (T		1515		2	1//	
	U.		M. THIMMARK	MAPPA 9	100	ESTERN	SHORE	DR,	SAL	ISBUR	YMD 21864
H	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	arked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2011 Gordon May \mathbf{A}^{M} Anderson 6:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7069 Basswood Road 21703 Frederick Social Security Number 8. Date of Birth (Month, Day, Year) Nov. 10, 1920 If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Ohio Director 273-09-9362 90 Nov. Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Frederick Frederick 5 10e. Street and Numbe 10g. Citizen of What Country? items 23a 7069 Basswood Road 21703 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates. WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 0 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White "natural". Completed 3 Widowed 4 Divorced any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Editor Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ August H. Anderson Rose Zeller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7069 Basswood Road Frederick, Maryland 21703 Barbara H. Anderson / Wife item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite 10, 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State 201<u>1</u> 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Pike Frederick, Maryland 21702 1621 Opossumtown Pike 23a. Part 1. Enter the disease ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ementic Medical Due to (or as a consequence of) xamine Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

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9 Unknown Pregnant at time of death Day Month Year been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy certificate 2 🗌 No Yes of Vital or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral (Certificate; 27. Manner of De 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work s after death. Division 2 Accident
3 Suicide 1 Yes 2 🗌 No Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and the of certifier D6041 MD

Registrar
DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygien ? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 05 2:20A M Karen Atkins Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 361 Marley Road E1kton Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖁 F Days Months Hours Min. 1271671965 Director 45 DE 221-48-8661 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Ceci1 E1kton MD 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? P pe Funeral er than "natural", or items 23a the Medical Examiner must b 361 Marley Road 21921 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No White 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Bartender Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fil f Health and Mental item 27 is marked ပ Francis DiAmario Darcy White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Wayne Reeves / Companion 361 Marley Road, Elkton, MD 21921 other tem 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or or 1

Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 05/13/2011 Elkton, MD 21. Signature of Juneral Service License 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. Klown 259 East Main Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) the attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for a in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy perform 1 🗌 Yes 2 🗎 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Speci 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of ess of person who completed cause of death (Item 23a) (Type, Print) 3 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ 2011 7:28am M Pau1 Brooks Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Queen Anne's Stevensville 404 Beach Side Drive Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1X M 2 Months 38 Director 214-08-7174 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director must be notified MD Queen Anne's Stevensville 1 XYes 2 No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 USA 21666-3916 404 Beach Side Drive items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Completed by "natural", or 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Parks & Recreation Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Donald Brooks Beverly Eileen Burton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 404 Beach Side Drive Stevensville, Md 21666-3916 Dawn Winger Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Cre. 5/8/201 1 Laurel, Md. Baltimore/Washington 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Rd. Bowie, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Santons honor Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown the detached 9 Unknown Division of Vital Records, P.O. þ signed by be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 thknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy death? certificate I 1 Yes 2 No To the Funeral Director: After this cerums completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify, after death. Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 0 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2011 Timothy Franklin Blevins May 2:18 p^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Carroll Dove House Westminster Social Security Numbe 9. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🔀 M 2 🗆 F Months Days Hours (Month, Day, Year) 67 **Director** 218-02-1736 43 Usual Residence of Decedent or 28a-f show 10b. County 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Carroll Hampstead 1 Yes 2 KNo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 4017 Shiloh Avenue 21074 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: white 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th Ceco Electric 12 electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gladys M. Anderson William L. Blevins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4017 Shiloh Ave., Hampstead, MD 21074 permit. Page 1 and 2 sl
Department of Health al
Important: If item 27 is Terri L. Blevins, wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Lakeview Memorial 5/11/2011 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home M00741 934 Main St., Hampstead, MD 21074 S. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death 10 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) ending physician a r use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 1 Yes 2 9 Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician; The law autopsy performed death? Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: INPATIET ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence funeral 27. Manner of Death Certificate: 4 hours after death. uneral Director: After the ed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npleted (Check within 24

To the F

complet Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Ad title of certifier 29b. Signature 29d. Date signed (Month, Day, Year) WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 Center St., Westminster, MD 21157 <u>Flavio Kruter</u> S. M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle | ast) 2. Date of Death Physician/ April 30ay **EVELYN** BRINKER 2011 2:39 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ATLANTIC GENERAL HOSPITAL WORCESTER BERLIN 5. Social Security Number Funeral 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Hours MARCH ^{Day} 8 • 1918 MTSSOURI Director 579-10-5721 93 Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director **DELAWARE** SUSSEX SELBYVILLE 1 🗌 Yes 2 ី No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 39001 CHICKEN FARM ROAD 19975 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces 1 Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐XNo Specify: 3 X Widowed 4 ☐ Divorced Specify: WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JOE THOMAS EVA RAVIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES THOMAS BRINKER SR./SON 39001 CHICKEN FARM ROAD, SELBYVILLE, DE. 19975 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ARLINGTON NATIONAL CEM UNKNOWN ARLINGTON, VIRGINIA 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause an each line ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Physician/ ai Medical resulting in death) consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Dav Yes 2 XX Pregnant at time of death 9 Unknown 9 Unknown that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 XNo Medical Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28c. Injury at work? 1 ☐ Yes 2 ☐ No ਰੱ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After X Natural 5 Pending injury Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying turse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signatura 29c. License number 29d. Date signed (Month, Day, Year) April 30, R 135131 510 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21811 9715 Healthway Dr, Berlin, MD Pennie Savage, CRNP 31. Date filed (Month, Day, Year) distrar's Signature State Registrar 0.5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0653 ZQ Benjamin Bowen Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TENINSUCA RAGIONAL SALIS6416 MEGICAL CIMICO Social Security Number **Funeral** 6. Sex 1 X M 2 ☐ F Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Days Months Hours Min. (Month, Day, Year) -3-1947 Pennsylvania Director 180-38-4217 63 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 K Yes 2 No PA Carbon Lansford 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral 430 East Bertsch Street should be filed within 72 hours after death vand Mental Hygiene.
is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-:: If item 27 is marked other than "natural", or iten or other traumatic event, the Medical Examiner 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give White 3 🗌 Widowed 4 🔀 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Roofer Roofing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Bowen, Jr. permit. Page 1 and 2 should Department of Health and M Important; If item 27 is mar any injury or other traumat once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Maniatty - Daughter 4232 Carry Back Road, Snow Hill, Maryland 21863 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 X Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Magdalene Crematory 5-11-2011 Ringtown, Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Prrt 1. Enter the disease, or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ ASCUD disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year ☐ Pregnant at time of death ☐ Unknown 9 Unknown P.0. signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? p Records, Completed 1 Yes 2 No 3 Probably 4 YUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 X Yes 2 □ No မ 1 ☐ Inpatient 2 🗹 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 4 hours after death. uneral Director, After this ed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director, After 1 🔼 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) 450493 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ate 100 € (aurol) ishum MD m 31. Date filed (Month State 05

DHMH 17 Rev 7/2009

Registrar

464.6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month May Jayden Michael-LeRoy Bacon 2011 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death 9 E. Pennsylvania Ave. Apt. Walkersville Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) MD 1 🛂 M 2 🗆 F Days Hours 0470672010 217-87-2452 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Pennsylvania Ave Apt. #1 21793 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 - Widowed 4 - Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aaron_M. Bacon Natasha L. Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Willis/grandmother E. Pennsylvania Ave. Apt#1, Walkersville, MD 21793 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 🛱 Cremation 3 🗔 Removal from State 4 Donation 5 Other (Specify) 5/6/2011 Stauffer Crematory Frederick, MD ture of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death

Ph sici n Medical Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed and

attending physician a for use as the burial-

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has been signed to should to

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e Funeral Director: After this leted filled in by the funeral dir

within 24 hours a To the Funeral I

Division of Vital Records, P.O. Box 68760

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ital Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at.

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permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Physician/Medical Completed by Be မှ Certificate: Medical

resulting in death)	a. Due to (or as a consequence of):	reg lange			
Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of):	ord leukm	la		- 11 montos
resulting in death) East	■ d		_		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1	ctopic pregnancy ther (specify)		23d. Date of d Month	elivery Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the unde	erlying cause given in Part I.		tobacco use contribute to	to the cause of death? Probably 4 Unknown
			per	topsy prior to rformed? prior to	utopsy findings available completion of cause of
25. Was case referred to medical examiner?	Hospital:	26. Place of Death (Che	eck only one)		
1 Yes 2 No	1 Inpatient 2 ER/Outpatient 3	3 ☐ DOA Other: 4 ☐ Nursing F	A Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Oth		
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be	311	28c. Injury at work? M 1 Yes 2 No	28d. Describe	e how injury occurred	
4 Homicide determined		factory, office	28f. Location City or To	(Street and Number or Ri bwn, State)	ural Route Number,
Check 2 ☐ Medical Exam	ysician: To the best of my knowledge, death occu niner: On the basis of examination and/or investigat rse Practioner: To the best of my knowledge, deat	tion, in my opinion, death occurred	at the time, date	and place, and due to the	cause(s) and manner state
29b. Signature and title of certifier	o MD	29c. License number D 0 0 6 2 8	91	29d. Date signed (Mon. 5/5/2)	th, Day, Year)
30. Name and address of person who	completed cause of death (Item 23a) (Type, Print))			

Washington DC

20010

State

Registrar

Shana Jacobs 31. Date filed (Month, Day, Year,

MAY 0

111 Michigan Ave.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month George W. Best 12:51 PM 201 Medical Facility Name (if not institution, give street and number, **Examiner** Town, or Location of Death 4c. County of Death Com isbur 6. Sex 1 X M 2 □ F If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign DC Country) Month, Day, Year) 11-27-1934 Months Director 578-42-4364 76 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No DE Sussex Laurel 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 11849 Hickman Drive 19956 permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Givmarines Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 X Never Married 2 Married Specify:White 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Plumber George F. Warner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Noah L. Best Mary E. Hensen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joe Best/Brother 11849 Hickman Drive, Laurel, DE 19956 timore, 20a. Method of Disposition

1 ☐ Buria 2 🎖 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Communication) Date 20c. Location - City or Town, State injury or Direct Crematory, 5-6-2011 4 Donation 5 Other (Specify) Dover, DE any inj 21. Signatu - Fun dal Service Licensee 22. Name and Address of Facility 917 W. Isabella St. Bal Bennie Smith Salisbury, Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ CANCRA disease or condition resulting in death) UNG Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) ___ Pregnant at time of death Month s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably Unknown 24a. Was an 24b. Were autopsy findings available certificate has birector, page 2 s prior to completion of cause of death?

1 Yes 2 No autopsy performed?
Yes 2 No Yes 25. Was case referred to medical fureral director, Be 26. Place of Death (Check only one) examiner? Hospita 1 🗌 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) HOSPICE 27. Manner of Death Platural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending efter death. Director: Af 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the I only one) 29b. Signature and the of certifier 2011

Registrar

318

State

U

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8760	
Box 6	
P.O.	
of Vital Records, P.O. Box 68760	
Vital	
n of	
Division	
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			Plea	se Type or Pı					_		gible	•	
		for State		State of N	/larylan		artment of H		Mental Hy	giene		16420	
	_	Registrar 1. Decedent's Name	a (First Middle	I set)		Cer	tificate of D	Death —-	0.000	Reg. No.			
Physicia Medic		JACQUEI		,	ILLER				2. Date of De Month	Day	Year 20	3. Time of Death 7:05 PM	
Examin		_		give street and number)				Location of Death		4c. Coun			
Funeral		5. Social Security No	HOSPIT	AL OF B.		nore ast birthday)	If Under 1 Year	IMURE If Under 24 Hrs.	8. Date of Bir	th	0 Bir	thplace (State or Foreign	
Director		189-32-5 Usual Residence of	5249	1 🗆 M 2 😾 F	69	Yrs.	Months Days	Hours Min.	June 2			nsylvania	
land show d at	tor	10a. State	10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits	
Mary 28a-f lotifie	irec	MD		Anne's	Suc	dlersv						1 ☑ Yes 2 ☐ No	
ith the 23a or st be r	Funeral Director	10e. Street and Nun					10f. Zip Code			10g. Citizen of What Country?			
ems 2	nne	114 MILI 11. Marital Status	ller St	12. Was Decedent	Ever in U.S	3. 13. V	21668 Vas Decedent of His	spanic Origin? (Sp	U.S.A. ecify Yes or No-			erican Indian	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Marri		Armed Forces 1 Yes 2 If Yes, Give		11	Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.) Black, Whi			e, etc.	
ours a atural	eted	3 😾 Widowed	4 Divorced	Year or Dates.	- 1					Specit		hite	
n 72 h an "na Medio	Completed	(Spe	cify only highes	t grade completed) College (1-4 or	E.\	(Give F	ent's Usual Occupa kind of work done d O NOT use retired)		ing	16b. Kind of I	Business	Industry	
withii ygiene her th t, the		12			3+)	Comp	uter Chip	Tester		Compu	ter	Components	
ntal Hied oth	To Be	17. Father's Name (Francis		*				18. Mother's Nam			ne)		
ould b nd Me mark imaric		19a. Informant's Na				10h Mailin	g Address (Street a	Kathryn			State 7ii	n Codol	
of 2 shalth ar alth ar 27 is		Lisa A.			r)	1	10 Sandpi			rtown,		· · · · · · · · · · · · · · · · · · ·	
of He If item or othe		20a. Method of Disp		3 ☐ Removal from Stat		lace of Disposemetery, crem	sition (Name of natory or other place	e)	Date	20c. Location	- City or	Town, State	
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permi Depar Impo any ir		21. Signature of	neral Service	2	M00!	E10 G	Name and Addres	s of Facility eral Hom	e of St	ephen L	. Sc	haech	
		23a. Part 1. Enter t	e disease, or o	complications that cause	ed the death		18 West C r the mode of dying				1635	Approximate	
Ph _{sician/}		Immediate Cause (I disease or conditio	Final	lly one cause on each li	PSIS							Interval Between Onset and Death	
Medical Examiner		resulting in death)	1	Due to (or as			1000					4 MONTHS	
	Jer.	Sequentially list cou	nditions,	b. — Due to /or or	o concogu	ioneo ofi:	NCER					·	
uted d ansit	al Examiner	cause. Enter Under Cause (Disease or i that initiated events	riying iinjury	MET	ASTA	TIC C	own c	ANCER				4 MONTHS.	
e executed cian and unial-transit	E E	resulting in death) L		Due to (or as	a consequ	ence of):				-			
ate be physic the bu	edica	d											
certific nding page as		IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome						23d D	ate of de	liven	
death e attel	sicia	in the past 12 r	months?	1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	at time of d		Ectopic pregnancy Other (specify)	/			lonth	Day Year	
at the did by the etache	Phy	9 □ Unknowň		is contributing to death		ulting in the u	aderlying cause give	on in Port I	00- 5:44				
ries tha signed	Completed by	DIABE		nellins			idenying cause give	arriir arci.	1 🗆			the cause of death?	
requi	lete	HYPER	TENSIC	N					24a. Was			topsy findings available	
Physician: The law this certificate has al director, page 2 3	dwo								autor perfo 1 \(\sum \) Yes	osy	prior to death?	completion of cause of	
sian: T ertifica ctor, p		25. Was case referre examiner?	ed to medical				26. Pla	ce of Death (Chec.		ZZNOI	T L Yes	s 2∐No	
Physic this or al dire	2	1 Yes 2 2 27. Manner of Death	-	Hospital: 1 XInpa 28a, Date of in		ER/Outpatien		4 L Nursing Ho				ify)	
ding th. After funer	cate	1 Natural 2 Accident	5 Pending	(Month, D		injury	28c. Injury work? M 1 🔲	eat Yes 2 □ No	28d. Describe h	now injury occur	red		
Atter er dea rector by the	Certificate:	3 Suicide 4 Homicide	6 Could no	ot be 28e. Place of In			et, factory, office				ber or Rui	ral Route Number,	
ital or urs aft ral Dir lled in	a C			1	tc. (Specify)				City or Tow				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2	Medical Ex	Physician: To the best of aminer: On the basis of Nurse Practioner: To the	examination	and/or investi	gation, in my opinior	n, death occurred a	t the time, date a	and place, and de	ue to the o	cause(s) and manner stated.	
To the within To the Comple		29b. Signature and t		A A			29c. License	number		29d. Date signe			
		1	101			MBB:	> RE	s 000)	MAY	, 16,	2011	
		30. Name and addre	ess of person w	ho completed cause of	death (Item	23a) (Type, P	rint)	BAITIM	10128. 24	101 W.R	FLUE	DERE AVE	
Stat	e	31. Date filed (Month	n, Day, Year)	LAR MBBS,	rar's Signatu	ure	FII AL OP	-5/10/11/	6	ALTIM	ORE	MD 21215	
Registra	_	MAY 24	2011	32. Regist	par	KN							

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05/1 1 2011 Year 2:10 Ronnie Gay Charest Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Burnett-Calvert Hospice House Calvert Prince Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X F Hours 49 01^M0171962 **Director** <u>220-62-8350</u> J Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at . 10a, State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Calvert Lusby 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20657 11500 Rope Knot Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Was Decedent 2.5. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 X No Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 11 permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eva Joy Fieth Ronald H. Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11500 Rope Knot Road, Lusby, MD 20657 Matthew J. Charest, Sr./Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Southern Mem. Gardens: 05/16/2011 Dunkirk, MD 22. Name and Address of Facility Lee 21. Signature of Funeral Service Licensee Funeral Owings, Home Calvert, P.A. MD 20736 Lisa M. Mounts 8200 Jennifer Lane, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Metastatic Cervical Cancer disease or condition ears Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ched for use as the burial-transit Due to (or as a consequence of). by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 X No Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed?

1 Yes 2 No s after death.

Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Burnett-Calvert 6 X Other (Specify Hospice House Other: မ 1 Tes 2 🗶 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a 29a. Certifier Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b, Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0059061 May 11, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jew 5 Arati Patel, MD, 100 Hospital Road, Ste. 212, Prince Frederick, MD 20678

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MAY

arke

32. Registra s Signature

2011▶

11-03428 Bradley Garrett C		Please Type or Print in Black Indelible Ink. Ensure All Copies State of Maryland / Department of Health and Mental Hy			16423
		1- For State Certificate of Death		eg. No.	. 0 / 22
Physicia Medical Examin		1. Decedent's Name (First, Middle,Last) Bradley Garrett Cox	2. Date of Dea Month	Day Year	3. Time of Death 1523 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	May 6, 20	4c. County of Deat	
		24808 Shrubbery Hill Court Damascus		Montgomery	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	1	3,1987 Ma	rthplace (State or gn
		Usual Residence of Decedent	pury r	3,1507 Ma	iryrand
w any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
land succe	5	Maryland Montgomery Damascus			1 Yes 2 XX No
Mary 28a-	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Cou	intry?
h the 3a or		24808 Shrubbery Hill Court 20872		US	SA
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Cuban, Mexican, Puerto Fig. 1) If Yes, specify Cuban, Puerto Fig. 2) If Yes, specify Cuban, Puerto Fig. 2) If Yes, specify Cuban, Puerto Fig. 2) If Yes, specify Cuban, Puerto Fig.		- 14. Race - Amer White, etc.	ican Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantel Hygiens "natural", or items 33a or 28a-f sho important: Witem 27 is marked other than "natural", or items 33a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ᇍ	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:	,		White
urs aft	≦	15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of working of the complete of the	ork done	Specify: 16b. Kind of Business	
72 hou	<u>ڇ</u>	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retire		TODA TANAL OF BUOM 1000	Madday
21215-0036 Uld be filed within 7 Montal Hygiene. marked other than c event, the Medica	Completed by	12 Assistant Manager		Ret	ail
5-0 Hygie		17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, f		
121 d be f fental arkec	Be	Gregory E. Cox Nancy Sa			
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Star Knapman Mary K. Cox/ Wife 24808 Shrubbery Hill Ct., Damascus, MD					
and 2 sho lealth and tem 27 is traumati	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery.	Date Date	mascus, MD 20c. Location - City or	ZU8 / Z Town, State
Ore ges 1 it of H it: If i		1 Burial 2 X Cremation 3 Removal from State crematory or other place) Metropolitan			
Baltimore, permit. Pages I an Oppartment of He Important: If ite Important: If ite Injury or other tr	-	4 Donation 5 Other Specify: Crematorium, Inc. May 21. Signature of Funeral Service Licensee / 22. Name and Address of Facility.	9,2011	Alexandria	, Virginia
		and O. Janley of Cfor Molesworth-Williams 26401 Ridge Road, D	amascu	s, MD 208/2	
Physician		23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or a falfure. List only one cause on each line.	respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
xaminer	1	Imme late Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Death
	-	b			
	늘	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	amine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):			
	נַ	events resulting in death) Last Due to (or as a consequence of): d.			
ox 68760, rath certificate be execute afterding physician and or use as the burial - trains	<u></u>	UNPENDED X AMENDED 19a per fh g915 5-26-11 vt			
'60, ate be	활	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliver	
687 ertific ding j	2	(3b). Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnance	су	Month (Day Year
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Pnysician/Medical	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown			
P.O. Bo that the de med by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Records, P.O. The law requires that the case has been signed by page 2 should be detact	2		1 Yes	2 No 3 Prol	pably 4 Unknown
ords, ** requir s been s should t	Сотріете		24a. Was a		topsy findings available
SCOI le law e has l	Ē		autop	med? death?	completion of cause of
Rec: The liftcate r, page	3	25. Who case referred to modified	1 ✓ Yes 2	2 No 1 V	es 2 No

Division of Vital Recc To the Hospital or Attending Physician: The lawithin 24 hours after death.

To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 2

To Be

Medical Certification:

1 ✓ Yes 2 No 26.Place of Death (Check only one) Other Nursing Home 5 Residence 6 🗸 Other: Scene DOA

28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Subject shot self 1 Yes 2 ✔ No 26f. Location (Street and Number or Rural Route Number, City or Town, State) 24808 Shrubbery Hill Court, Damascus, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc.

CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and ma	anner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a	and due to the cause(s)

Tremede			,		•
29a. Certifier (Check only 1 Certifying Physician:	To the best of my knowledge, death occurred a	at the time, date and place, and	due to the cause(s) and manner as	stated.
	ithe basis of examination and/or investigation, i d manner stated.	in my opinion, death occurred at	the time, date and	d place, and due t	o the cause(s)
29b. Signature and title of certifier	· · ·	29c, License number	29	9d. Date signed	(Month, Day, Year)
Quets -		O.C.M.E.		/lay 7, 2011	,

30. Name and address of person who completed cause of death (Item 23a)

Pending

6 Could not be

Investigation

determined

Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Hospital: 1 Inpatient 2 ER/Outpatient 3

28a. Date of Injury FOUND: Day,Year)

(Specify) Shed

May 6, 2011

31. Date filed (Month, Day, Year) State Registrar

25. Was case referred to medical

examiner?

1 Natural

2 Accident

3 V Suicide

4 Homicide

1 🗸 Yes

27. Manner of Death

32. Registrar's Signature

FOUND:

1515 hrs

OCME

5

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JOHN FRANCIS Medical COVAHEY May 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick Social Security Number **Funeral** 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 1 X M 2 | F Days Hours Director 218-14-1172 87 Oct. Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1103 Wilson Place 21702 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 2 1 Never Married 2 X Married X Yes 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 ☐ Widowed 4 ☐ Divorced Specify: Completed Year or Dates. WWII other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Atomic Energy Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerk Commission marked other Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H ၉ John Thomas Covahey Mary Leonard 19a. Informant's Name/Relationship (Type, Print) 1 and 2 shou of Health and item 27 is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1103 Wilson Place, Frederick, Maryland 21702 Sara Covahey/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ot 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Inc.5/9/2011 Frederick, Maryland. 21. Signature of Foneral Service Licens 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Homes P. A. Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Dreumano Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Į in the past 12 months?
1 Yes 2 No Month Pregnant at time of death signed by the a 1 Yes 2 L 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Records, Disorday Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed' certificate Yes 2 No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending n 24 hours after death.

e Funeral Director: After the function is the function of the function is the function in the functio 1 Yes 2 🗌 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the I within 2 To the I only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

16424

3. Time of Death

4:38

g. Birthplace (State or Foreign

10d. Inside City Limits

Interval Between

Onset and Death

Year

Day

2 No

1X Yes 2 ☐ No

Maryland

White

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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D57643

Bamas Johnson & Frederick

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Month Year 1125 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Heartfields Prince George's Bowie Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last hirthday) 8. Date of Birth Months Days Hours Min April 25 1 M 212 F ar) 1921 578-12-1278 Afexandria, VA Director 90 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No M Talbot. Queen Anne 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 30112 Pahlmans Lane 21657 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ş 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wade Wharton Sabre Jane Compton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Austine C. Clagett / Daughter 30112 Pahlmans Way, Queen Anne, MD 21657 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cent 5/11/11 Crownsville,MD 21. Signal f Funer | Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Year Pregnant at time of death Day the g Unknown Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the nosponer of within 24 hours after death.

To the Funeral Director, After this certificate has lead to the fulled in by the funeral director, page 2: performed 2 No Yes 2 W No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 ☑ No Other: 힏 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Many of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 / Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cal of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of de GENEVEVE LEGHT FOOT-TAYLOR 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

1 0 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - State Registra Certificate of Death 3. Time of Death 2 Date of Death . Decedent's Name (First, Middle, Last) Month 4 2^{Day} 2011 **Physician** Filmore Christopher, Sr. 2:10 pM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1203 Sherree Lane Princess Anne Somerset If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 3-26-1936 Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 75 Yrs MĎ Director 219-34-2800 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla artment of Health and Mental Hyglene. ortent: if Item 27 ie marked other than "natural", or Items 23a or 28a-1 ehov injury or other traumatic event, the Medical Examinar must be institled at 1 Yes 2 No by Funeral Director Somerset Westover 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 30274 Fooks Lane 21871 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No SpecifyBlack 3 ☐ Widowed 4 X Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Trucking/Farming Truck Driver 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Christopher Mary E. Wright 19a. Informant's Name/Relationship (Type, Print) Grand-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tasha White-Bailey/daughter 1203 Sherree Lane, Princess Anne, MD 21853 20b. Place of Disposition (Name of Licensel Difference of Camerica Constitution of Flower Hill Cem 5 20a. Method of Disposition Date 20c. Location - City or Town, State 5-16-2011 -7-2011 Dover, DE. Eden, Bennie Smith W. Isabella St. Departiment any injusting 21. Signature of Futural Service Licensee Funeral Home Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Severe COPD **Physician** /Medical Examiner Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes cate has been sig , page 2 should b 2 🗆 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy perform 2 X No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

lasser,

29b. Signature and title of certifier

mald

30. Name and address experson who completed cause of death (Item 23a) (Type, Print)

Roadd Casser, MP Rennaula II tenal Medicine 32. Registrar's Signature

Rennovla In-

MO

29c. License number

060958

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 **Physician** 5:55 A. M Irma Mildred Dorsey May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince Frederick Calvert Memorial Hospital Calvert | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 13, 1 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 ☐ M 2 🕅 F 217-32-9170 1932 Director Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Director 1 ☐ Yes 2 X No MD Calvert Chesapeake Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 21 is marked other than "natural", or Items 23a or 1 any hiury or other traumatic event, Ir. Medical Extra in 1 usafter. U.S.A. 4350 Christiana Parran Road 20732 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No If Yes, Give Year or Dates: Specify ģ Specify 3 X Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ε. Hance, Jr. Edith C. Meade မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20732 19a. Informant's Name/Relationship (Type, Print) John H. Dorsey, son 4350 Christiana Parran Rd., Chesapeake Beach, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Emmanuel UMC Cemetery 05/12/2011 | Huntingtown, MD Sign of Funeral Service Lio 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the dis-ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failule. List only one cause on each line. Approximate Interval Between Onset/and Death Immediate Cause (Pnal/ disease or condition resulting in death) **Physician**)ai /Medical Due to (or as consequence of): Examiner 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner ear requires that the death certificate be executed Exami onar Due to (or as a consequence of): burial-1 Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Vear Day Pregnant at time of death 5 ☐ Other (specify) signed by the a Ö 9 Unknown 9 Unknown σ, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ∑ es 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was a... autopsy performed? vas 2 No page 2 Physician: The certificate 2 No Division of Vital 1 🗌 Yes 1 ☐ Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of D ath Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the 1

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State Registrar title of cer

e and address of person who co

Year,

29b. Signature and

oma

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

neted cause of death (Item 23a) (Type, Print)

100

32. Registrer's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May2011 Russell Dove 4, 5:28 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 864 W. Bayfront Road Anne Arundel Lothian Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 1 🗓 M 2 🗆 F 0672471921 Mary Tand Director 89 218-14-3138 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD Anne Arundel Lothian 1 🗌 Yes 2 💢 No 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 1073 Marlboro Road 20711 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. 0 \$ 1 Never Married 2 X Married 1 X Yes (2 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiens. Important: I fiem 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal any injury or other traumatic event, the Medical Exal Completed 3 Divorced 4 Divorced Year or Dates. 1945-47 white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) farmer agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Joseph Louis Dove Omie Mae Lincoln 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Dove, son 864 W. Bayfront Road, Lothian, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, MD Veterans Cemetery 05/13/2011 Cheltenham, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. ature of Funeral Service Licensee 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death
3 1/2 YEAV Immediate Cause (Final muelowa Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examin burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical requires that the death certificate be attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 2 🗌 No as been signed by the 2 should be detached 9 Unknown a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death.
Funeral Director: After this certificate has b performed? Yes 2 No 2 🗆 No 1 🗌 Yes 25. Was case referred to medical examiner? Be funeral director 26. Place of Death (Check only one) Hospital Other: 2 No SON'S VESILENIE 1 \square Yes ျှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the l within 2 To the f only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year) 5/6/2011

dRW 5+

Box 68760

P.O.

Division of Vital

State Registrar Stuaut

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

2003 medical Parkway, Annapolis, Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Solonich, uo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Physician/ Day 09 Yea 201 4:46P M Lucille R. Davies Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ceci1 630 McKinneytown Road Elkton Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 M 2 X F Months Hours Min Yrs. 71171939 **Director** 222-24-0211 VA Usual Residence of Decedent fshow 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Ceci1 E1kton MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21921 630 McKinneytown Road hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc.
... White ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: Specify 3¥⊠ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) W.L.Gore (textiles) Secretery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Kathleen Miller Otis Huff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 630 McKinneytown Road, Elkton, MD 21921 Jennifer Demond / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) <u>Delaware Vet. Cemetery 05/16/201</u>1 Bear, DE neral Service Licenses R.T. Foard Funeral Home, P.A. 22. Name and Address of Facility E1kton, MD 21921 259 East Main Street, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Priysician, disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cauce. Ener Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the bunal-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death signed by the at d be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s has autopsy performed this certificate 1 Yes 2 No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\overline{\text{M}}\) Residence 6 \(\sum \) Other (Specify) 1 ☐ Yes 2 ☑ No Hospital ၉ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours are reach.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending __ ivatural
☐ Accident
☐ Suicid 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of ertifier 29d. Date signed (Month, Day, Year) such cles S MD 00023322 5.10.2011. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S-S SACHDEV MD, 1264 E High Elpton MD 21921

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 75 20°1°1 MAY LYNNETTE MAUREEN DRAHEIM 2:38 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES LA PLATA 11895 AMY DRIVE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year 971 1 □ M 2**X X** Hours JAN . 15, NORTH CAROLINA 215-19-5875 40 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he material and 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 X No CHARLES LA PLATA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20646 U. S. A. 11895 AMY DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. by 1XXNever Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) SALES ASSOCIATE T. J. MAXX Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ၉ DIANA LYNN MUCHOW GARY W. DRAHEIM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANA L. DRAHEIM/MOTHER 11895 AMY DRIVE LA PLATA, MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition MAY^{Date} 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State TRINITY MEM.GRDNS. 20, 2011 WALDORF, MARYLAND 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. NEOPLASM On at and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (of as a consequence of). attending physician and for use as the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 ☐ No signed by the a d be detached f 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Tes 2 No 3 Probably 4 Unknown Completed After this certificate has been strunged the function of the strunged of the s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 🗌 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 IDCA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) |은 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work' 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier

State Registrar 102 PAULMEllon CT

2011

WALDORF MD 20602

AHENDING

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHVINKUMAR

31. Date filed (Month, Day, Year,

MAY 24 2011

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1 5 Day 201°1 11:41P M BARBARA ANNE DAUGHTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 4/2/1941 West Virginia 70 219-40-2643 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Whiteford MD Harford 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be r Funeral 2220 Whiteford Road 21160 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 1. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ▼No Specify: Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harold Scott Clara Mae Grannen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Royston E. Daughton/Spouse 2220 Whiteford Road, Whiteford, MD 21160 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mary's Cem. 5/20/2011 Pylesville, MD 21. Signature of Euneral Service Lic 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, 7314 May 15,2011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Preumoria nciear disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** inclear Acute renal Sequentially list conditions, if any hading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Sepho Sheck ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of) Physician/Medical days respiration of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Daughten, Barbara in the past 12 months?

1 Yes 2 No ☐ Live Birth 2 ☐ Fetal Seat ☐ Pregnant at time of death ☐ Unknown 5 Other (specify) Month Dav Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Encephalopathy 1 ☐ Yes 2 ☐ No 3 ▶ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Obstructive pulminary 24a Was an has autopsy performed 1 Yes 2 No 25. Was case referred to medical Hospital or Attending Physician; 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death.

Funeral Director, After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of funeral 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 Yes 2 No Division 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May, 16, 2011 00065421 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chesopeake Drive, Bel Air, Maryland 21014. FisHer 500 Upper 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 24 2011 Registrar

DHIVIH 17 HeV 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May Month Day Physician/ 06, 2011 6:22 P. M Buckler Gibson Frances Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Huntingtown 295 Cox Road If Under 1 Year If Under 24 Hrs Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months Days Hours MaryTand 169111911927 Director 83 217-24-0052 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show among injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Director 1 Yes 2 X No Huntingtown Calvert 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 20639 295 Cox Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black White etc. 1 ☐ Yes 2 🏋 No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify: Specify: 3 X Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Postal Service 12 postmaster 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Buckler, Sr. Lee Trott Jesse Calvert Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 255 Cox Road, Huntingtown, MD Richard Franklin Gibson, son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Huntingtown UMC Cemetery 05/10/11 Huntingtown, MD 4 Donation 5 Other (Specify) f Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, Approximate Interval Between Ons t and Death 23a. Part 1. Enter the disea se, or complications t hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure Immediate Cause (Final Physician/ Cerebrovascular I disease or condition EMY Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine heroscierosis ems or Attending Physician; The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death for use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Dav Year 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Carenoma 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🕦 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work 2 Accident 1 🗌 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29b. Signature and title of certifier 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dRW Gerald P. Sterner, MD, 19 Chesapeake Beach Rd.E., Owings, MD 20736

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May May 5 Day 011 Year Nancy Mildred Geary 5 Ρ. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2509 Bidle Rd. Middletown Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 F Min. Hours 70 Director 213-40-5132 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Middletown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2509 Bidle Rd. 21769 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 XNo Specify: 3 ☐ Widowed 4 ★ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) $\overset{\text{Elementary/Seconday (0-12)}}{12}$ College (1-4 or 5+) conveyer operator newspaper permit. Page 1 and 2 should be filed witi Department of Health and Mental Hygie Important: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Archie Oliver Hood Helen Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9320~Mt.~Tabor~Rd.,~Middletown,~MD~21769Norma Gossart (Daughter) Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burjal PX Cremation 3 Removal from State Smithsburg Crematory5/9/201 Smithsburg, MD pecify) ature of Fundal Service ²²Donald ¹⁶ B. Thompson Funeral Home 31 E. Main St., Middletown, MD 21769 Part 1. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between hock, of heart failure. List only one cause on each line use (Final Onset and Death Physician/ orona Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗆 Yes 2 No Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death completed filled in by the funeral Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No hours after death uneral Director: / Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral L Medical 29a. Certifler Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1286 Unger 31. Date filed (Month 32. Registrar's Signature State Registrar

Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month HILDEGARD M. GROVES **MAY 07** Medical 2011 3:51 P 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 236 DUKE OF KENT STREET **CHESTERTOWN** QUEEN ANNE'S 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Hours 08/07/1925 Director GERMANY 214-34-5249 85 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No CHESTERTOWN MD QUEEN ANNE'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 236 DUKE OF KENT STREET 21620 UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ■ XNo Specify: Completed 3 X Widowed 4 Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOSEPH ZILLER THERESE BOGNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES GROVES / SON P.O. BOX 223 WORTON, MARYLAND 21678 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) POND CEMETERY **STILL** 05/14/2011 STILL POND, MARYLAND 21. Signature of Funeral Service Lice 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND Approximate Interval Between Opset and Death 23a. Pan 1. Enter the disease, or complication shock, or heart failure. List only one cause that caused the death on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Ph_sician/ disease or condition Min Medical resulting in death) Examiner Due to (or as consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the at d be detached for Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s this certificate 1 Yes 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 🗌 Yes Other: in 24 hours απει τους... he Funeral Director, After this α maleted filled in by the funeral di 1 Inpatient 2 IER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 24 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ertifie 29d. Date signed (Month. Dav. Year) ess of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month.

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M.D

Chestertown, MD 21620

Decedent's Name							0.5 1 1-	41			
NELLTE	,	GREENWOOI	1				2. Date of De Month	D		ear	3. Time of Dea
					4b. City, Town, o	or Location of Dea	MAY ath	05		011 Death	6:00
HEARTFIE	LDS ASSI	STED LIVI	NG		EASTON						
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	9/8			90 115.			MAY 06), I	920 I	PENNS	SYLVANIA
10a. State 10b. County			10c. Ci	ty, Town or Loc	ation					10	Od. Inside City Li
MD KENT			ST	ILL PON							1 🗌 Yes 2
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11. Marital Status	THE TORI	12. Was Decedent	Ever in U.		as Decedent of F	Hispanic Origin? (Specify Yes or No-				
1 Never Marri	ied 2 🗆 Married	1 ☐ Yes 2 X	?] No				rto Rican, etc.)			White, et	tc.
3 ★ Wildowed 4 □ Divorced Year or Dates.									V		
(Specify only highest grade completed)				(Give k	ind of work done	during most of we	orking	16b. I	Kind of Busi	ness Inde	ustry
Elementary/Seconday (0-12) College (1-4 or 5			5+)	1	_ ′			E	LON		
17. Father's Name (First, Middle, Last)						18. Mother's N	ame (First, Middle,	, Maiden Surname)			
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		/ SON	20b. I			POND ROA					
1 X Burial 2	Cremation 3		е (cemetery, crem	atory or other pla	· · ·				•	
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								70	7 YEA		
23b. Was decedent in the past 12 r 1 Yes 2 • 9 Unknown	al death 3 death 5	S ☐ Ectopic pregnancy					23d. Date of delivery Month Day Year				
Part II. Other signifi	icant conditions	contributing to death	but not res	sulting in the ur	nderlying cause gi	iven in Part I.		d tobacco use contribute to the cause of death			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1									pletion of caus		
examiner?		Hospital:					eck only one)				ASST.
		1 ☐ Inpat			3 🗆 DOA	4 ☐ Nursing			nce 6 X Other (Specify)LIVING		
1 🗹 Natural	5 Pending	(Month, De	ay, Year)	injury	worl	k?	28d. Describe i	now injui	y occurred		
3 Suicide 6 Could not be									or Rural F	Route Number,	
(Check 2	Medical Exan	iner: On the basis of	examinatio	n and/or investi	gation, in my opini	on, death occurred	d at the time, date a	and place	e, and due to	the caus	se(s) and manne
29b. Signature and t	itle of certifier	104		h i0				29d. Da	ate signed (A	Agnth, Da	ay, Year)
	> 4	W PP-C				24198		5	15/	411	
30 Name and added	ss of person who	completed cause of	death (Item	23a) (Type Pr	int)				1) 1	+101	
	HEARTFIE 5. Social Security N 219—36—6 Usual Residence of 10a. State MD 10e. Street and Nun 13180 S7 11. Marital Status 1 Never Marr 3 N Widowed (Spe Elementary/Secc 12 17. Father's Name (I) RALPH DA 19a. Informant's Na JIMMY GF 20a. Method of Disp. 1 N Burial 2 4 Donation 21. Sunature of Fur 1 Natural Status Sequentially list con a cause. Enter tunder Cause (disease or condition resulting in death) Sequentially list con a cause. Enter Under Cause (Disease or that initiated events resulting in death) IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 Sequentially list con a cause. Enter Under Cause (Disease or that initiated events resulting in death) IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 Sequentially list con a cause. Enter Under Cause (Disease or that initiated events resulting in death) IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 Sequentially list con a cause. Enter Under Cause (Disease or that initiated events resulting in death) IF FEMALE: 23b. Was case referred a cause (Disease or condition that initiated events resulting in death) 25c. Was case referred a cause (Disease or condition that initiated events resulting in death) 27c. Manner of Death and Condition that initiated events resulting in death) 28c. Was case referred a cause (Disease or condition that initiated events resulting in death) 29d. Certifier 1 (Check 2 only one) 3	##EARTFIELDS ASSI 5. Social Security Number 219—36—6978 Usual Residence of Decedent 10a. State 10b. County ### MD	Social Security Number 219-36-6978 1	### HEARTFIELDS ASSISTED LIVING 5. Social Security Number	HEARTFIELDS ASSISTED LIVING 5. Social Security Number 219—36—6978 Social Security Number 219—36—6978 Social Security Number 219—36—6978 10b. County	## HEARTFIELDS ASSISTED LIVING 5. Social Security Number 219-36-6978 Second Security Number Second Se	HEARTFIELDS ASSISTED LIVING PASSISTED LIVING PASSISTED Security Number 6. Sex 219—36—6978 1	48. Figure Name Find Intelligence Social Security Names 5. Secial Security Names 5. Secial Security Names 5. Secial Security Names 6. Sec 100. County 100. City 100.	46. Facility Name (front institution), give street and number) HEARTFIELDS ASSISTED LIVING 219–36-6978 Limit Social Security Number 219–36-6978 Limit Social Security Number 219–36-6978 Limit Social Security Number 100. Colley, Town or Localion KENT STILL POND 100. Street and Number 101. States and Number 110. Street and Number 113.80 STILL POND ROAD 216-67 11. Mariat Status 12. Wiss Decodert Ever in U.S., Armore of pregnancy or Number of Pirat, Middle, Last) 13. No Street and Number 13. Decodert's Education 14. Decodert's Education 15. Decodert's Education 16. Decodert's Education 16. Decodert's Education 17. Tather's Name (Pirat, Middle, Last) 18. April 1. First the Glasses, or complications that based of the present spice of pregnancy in death of the present spice of pregnancy in the present spice of present spice of pregnancy in the present spice of	46. Carly Name of not restriction, give street and number) 40. Carly view, and the property of the propert	46. Cally Name of not institution, give street and number) 46. Cally Name of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Richard J. Gosheff May 6 11:28 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3115 Gosheff Lane Gambrills Anne Arundel Birthplace (State or Foreign Country)
 Ohding Social Security Number 6. Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs **Funeral** Age (In yrs. last birthday) 8. Date of Birth Months 1/19/1927 218-36-3109 84 Yrs Ohio Director Usual Residence of Decedent 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔽 No Maryland Anne Arundel Gambrills 10e. Street and Number 10g. Citizen of What Country? Funeral 3115 Gosheff Lane 21054 USA 12. Was Decedent Ever in U.S. Argyed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give ₩ ₩ Τ 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: rr Yes, Give W.W. Specify: 3 Widowed 4 Divorced IIWhite 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Farming Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Slavko Gosheff Hilda Beck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betsy L. Scible/ Niece 3161 Gosheff Lane, Gambrills, MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Hillcrest Cemetery 1 X Burial 2 Cremation 3 Removal from State 5/11/11 Annapolis, Maryland 4 ☐ Donation 5 ☐ Øther (Specify) 21. Signatura de Juniera Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cancer Lung disease or condition 4 months Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Dause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of) Examin attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year signed by the a d be detached f 1 Yes 2 L 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 1 ☐ Yes 2 ☐ No Yes the Hospital or Attending Physician: the Funeral Director: After this certific pleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, 2 No Other: ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4
Nursing Home Residence 6 D Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending death. Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Pate signed (Month, Day, Year) 29b. Signatui 29c. License number 65072 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of vite 210

Registrar DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

P.O. Box 68760

Division of Vital Records,

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32. Res

istrar's Signature

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NO 21/1000 AD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Dorothy Mae Gochenour May 16, 9:18 P.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 16811 Raven Rock Rd. Sabillasville Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** Birthplace (State or Foreign
Country) 212-24-6547 Days Year) 1 □ M 2 🔽 F Months Hours (Month, Day, **Director** 83 Maryland Jan Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Md. Frederick Sabillasville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16811 Raven Rock Rd. 21780 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc.
White þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 ☐ Yes 2 No Specify If Yes, Give Year or Dates. Completed 3 ☐√Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other to any injury or other traumatic event, the once. <u>Homemaker</u> Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George Franklin Kuhn Edith Marie Roof 19a. Informant's Name/Relationship (Type, Print) Sue Ann Smith (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15121 Dutrow Ave. Blue Ridge Summit, Pa. 17214 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bethel Cemetery 20a. Method of Disposition 20c. Location - City or Town, State May [□]19. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cascade, Md. 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Funeral Service Licence 22. Name and Address of Facility 12525 Bradbury Ave. M0141 J.L. Davis Funeral Home Smithsburg, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Pnysician/ failure disease or condition resulting in death) renal Medical Due to (or as a consequence of) **Examiner** vascular disease pertensive Sequentially list conditions, Examine cause. Enter Underlying **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ congestive heart failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Fibrillation 24b. Were autopsy findings available 24a. Was an atria prior to completion of cause of death? autopsy performed? 2 No Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 1 No Hospital: Other: 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 \square Yes (Month, Day, Year) 1 Natural injury 5 Pending 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number D47451 May 17, 2011

Registrar DHMH 17 Rev 7/2009

State

747 Northern Avenue

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Ynthia Kuttner - Sands, mb Hospice of Washington County

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:00 A M reston Hensen 2011 Medical AL 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death 103 Hei 5. Social Security Number WUnder 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Month, Day, Year 7. Age (In yrs. last birthday) 6. Sex **Funeral** 9. Birthplace (State or Foreign 1 🗷 M 2 🗆 F Mary and 668 Yrs. Director 62 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or no once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MARTIAND 10e. Street and Number 10g. Citizen of What Country? Funeral 20747 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ρ 1 Never Married 2 Married 1 Yes 2 If Yes, Give 2 2 No 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Adams Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>621</u>1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State cemetery, crematory or other place. 4 ☐ Donation 5 ☐ Other (Specify) 5 Signature of Fureral Service Licens 22. Name and Address of Facility 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrested shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): threw Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury 0 for use as the burial-tran that initiated events resulting in death) Last Due to (or as a conseque within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Ridney Donce Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2 N 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 10 Hospital 1 🗌 Yes 24 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20602 V. Javanthan maladevi 3728 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- Registrar Amended #19a PerFH FCHD KS 5 13 11 Reg. No.

Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 45 AM **Physician** ,2011 tendrix lar /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year) JAN . 15 , 1941 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday, Days **Funeral** 1 □ M 2 🗓 F 70 Washington, DC 218-38-5616 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1X Yes 2 □ No Director Frederick Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21702 United States 97 Kearney Court Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White ģ 3 X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) d 2 should be filed withir th and Mental Hygiene. 7 is marked other than Homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) traumatic event. 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ment of Health and Mental ant; If item 27 is marked Lillian Lowes Frederick Baumann ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tracy A Moregon Tracy A. Morgon/daughter 21702 97 Kearney Court / Frederick, Maryland permit. Pages 1 and Department of Health Important: If item 2: any Injury or other tonce. 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 05/06/2011 Stauffer Crematory Frederick, Maryland 4 Donation 5 Other (Specity) 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 0 1621 Opossumtown Pike/ Frederick, Maryland 21702 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Finer the disease. shoc!, or heart failure. List only one cause on each line. Immedia Cause (Final severe Physician aurtic stenosis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner amyloidosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and is the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical as use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No Day detached for Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown ρ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>\$</u> 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 🗌 Yes 2 No Yes 26. Place of Death (Check only one) 25. Was case referred to medical director, Be examiner? 2 No Hospital: 1 🔏 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 \sum Yes 2 ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Magner of Death Certification: 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide the Hospital XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one) 29c. License number 29b. Signature and title of certifier RES- 000 May 2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Kristina

600 North Wolfe St, Baltimore, MD, 21287

Ms

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ana Rubio MD. 31. Date filed (Manth Cry Year 32. Registrar's Signature 2011

barrens.

30. Name and address of person who completed cause of death (Item 23a)

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 13, 2011

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Registrar

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29b. Signature and title of certifier

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Sidney Merlia Harris May 2011 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 2, 2011 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. 55 Days Hours 1 M 2 XF N/A 0 Yrs Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland show. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ 1 ☐ Yes 2X No or 28a-f s notified Director Odenton MD Anne Arundel 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö ral", or Items 23a or Examiner must be 2480 Warm Spring Way 21113 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑No
If Yes, Give
Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status , or h 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 Divorced Specify: African American "natural" Completed 15. Decedent's Education Decedent's Usual Occupation 16b, Kind of Business/Industry Medical (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. the N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Douglas Harris, III Tiffany C. Laird ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 I 2480 Warm Spring Way, Odenton, MD 21113 Carl D. Harris, III/Father item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot Burial 2 Cremation 3 Removal from State Arlington Nat'l Cem. 5/18/2011 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licenses 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. 6aft 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 1/19 +a disease or condition on resulting in death) /Medical ue to (or consequence of): Examiner matur Sequentially list conditions Examiner Due to (or as a consequence of). cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Day 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 2No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ★Yes 2 □ No 24a. Was an autopsy performed? has s after death.

Director: After this certificate 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA ည the funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D To the Hospital 29a, Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and titl 29c. License number 29d. Date signed (Month. Dav. Year)

State Registrar

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30. Name and address of person was

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completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

2011

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#1 Per PHY State of Maryland / Department of Health and Mental Hygiene-State Registrar 5 / 10/2011 AACO HEALTH DEPT OMH Certificate of Death 1. Decedent's Name (First, Middle, Last) B. Grace Hazzard 2. Date of Death 3. Time of Death Physician/ May 4,201 7:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7196 Fir Street Talbot Easton 8. Date of Birth Month, Day Year) NOV • 19, 1928 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗙 F Months Davs Hours Min. 493-30-6604 Director 82 Mississippi Usual Residence of Decedent or 28a-f shov ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD Talbot Easton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7196 Fir Street 21601 USA 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 X Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 Is and Mental Hygiene.
7 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automobile Safety Dept. of Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Clarence Henrv Hazzard Eunia Cunningham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Mary Rose Hazzard / Sister 7196 Fir St., Easton, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/9/2011 Lakemont Mem. Gards. Davidsonville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home any 6512 NW Crain Hwy., Bowie, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ adult disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** erebrovascular Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the burial-transit demented that initiated events Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Other (specify) Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 🗹 No Hospital 1 Tyes Other: မ 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined. Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D0059939 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) River Physicians 508 Idlewild Avenue 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Paul Ledley Hooper Sr. May 1, 2011 9:56 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 937 Winding Way Salisbury Wicomico Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 X M 2 □ F Months (Month, Day, Year) 03/12/1923 Country) Virginia Director 154-18-8979 88 Usual Residence of Decedent 28a-f show 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Wicomico Salisbury 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 937 Winding Way 21804 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ⚠ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Completed 3 X Widowed 4 □ Divorced Specify: white Year or Dates. Army 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " College (1-4 or 5+) Dept. of the Interior Elementary/Seconday (0-12) Biologist Fish and Wildlife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers of the second မ permit. Page 1 and 2 should be I Department of Health and Menta Important: If item 27 is marked Thomas Beale Hooper Bessie Videll Ledley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Sullivan/daughter 8314 Haven Hill Court, Laurel, MD 20723 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salisbury Crematory 20c. Location - City or Town, State Date injury or 1 Burial 2 X Cremation 3 Removal from State 5/4/2011 Salisbury, MD 4 Donation 5 Other (Specify) Signature of Funcial Service Licensee 22H0TToway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Dusito (or as a consequence or): the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day Year 2 No the 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 should be Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy page performed. Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one, Hospital Other: Certificate: To 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending iniury ___vatural __ Accident __ Suic 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined e Funeral C Medical *Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 04/26/2011 ROBERT INSLEY, JR. 1917 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgamery If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth Days 1 🛛 M 2 🗆 F Hours 01/08/1929 Director 82 <u>386-36-3089</u> Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Director 1 XYes 2 No MD Rockville Montgomery b 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 203 S. Washington Street 20850 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Examiner Armed Forces?
1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō 1 Never Married 2 Married þ 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 X Widowed 4 ☐ Divorced Completed Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+ Prince George's Gyt. Systems Analyst Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy Important: If item 27 is marked any injury on the state of the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert Insley, Sr. Jane McCrea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James C. Insley/son 60 Allen Street, Walpole, Mass 20281 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal to 4 🗆 Do Ardent Gremation Svc 04/28/11 Hanover, MD 21. Signature 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 22a. Part 1. Enter the dise se, or compli . Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur Immediate Cause (Final Onset and Death Physician Atherosclerosis cardiovascular disease disease or condition Medical resulting in death) Due to (or as a sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-trynsit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day 4 Pregnant at time of death Month Year Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Diabetes type 2; coronary arter disease; Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? multiple myeloma; artial fibrillation; 24a. Was an autopsy performed? Yes 2 X No chronic kidney disease: stage IV IV 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 💢 critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D53367 04/27/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rajan Shyamsundar, MD 9801 Georgia Avenue, #117, Silver Spring, MD 20902

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MAY 06 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ba1kcom Iozzia Warreen 5:02A May 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery 6408 Brass Bucket Court Laytonsville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Oct. 19 Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) 1 🗆 M 2 🔀 F 93 Yrs. 254-10-2390 1917 Georgia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Laytonsville Montgomery 1 Yes 2. No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20882 6408 Brass Bucket Court United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗹 No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Clerk/Typist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emma Gene Collier Luther Warren Ba1kcom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 6408 Brass Bucket Court, Laytonsville, Md. 20882 Jeannie C. Harvey/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5/7/11 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. At re of funeral S rice Vicensee 22. Name and Address of Facility Muriel H. Barber Funeral Home P. 0. Box 5038, Laytonsville, Md. 20882

Physician/ Medical **Examiner**

the attending physician and hed for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a. State

Md.

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov amy injury or other traumatic event, the Medical Examiner must be notified.

Baltimore, Maryland 21215-0036

Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur þ Medical Certificate: To Be Completed

29b. Signature and title of certifier

31. Date filed (Month,

Geoffrey Coleman,

	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
	Immediate Cause (Final disease or condition	Osteoporosis									
	resulting in death)	Due to (or as a consequence of):		<u>ye</u> ars							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury	nmediate Due to (or as a consequence of):									
	that initiated events c. resulting in death) Last	Due to (or as a consequence of):									
	d.										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 N No 9 Unknown	c. If yes, outcome of pregnancy 1	23d. Date of de Month	livery Day Year							
	Part II. Other significant conditions cont	ributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?							
-											
3	Diabetes Mel	litus	1 ☐ Yes 2 ☐ No 3 ☐ P	robably 4 🗷 Unknown							
	HTN		autopsy prior to performed? death?	topsy findings available completion of cause of							
	25. Was case referred to medical	26. Place of Death (Chec									
	1 LI Yes 2 E No	spital: 1	ome 5 🗹 Residence 6 🗆 Other (Spec	eify)							
	27. Manner of Death 1	28a. Date of injury (Month, Day, Year) 28b. Time of Injury Injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred								
	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Ru City or Town, State)	ral Route Number,							
	(Check 2 Medical Examine	ians: To the best of my knowledge, death occured at the time, date and place, ar r: On the basis of examination and/or investigation, in my opinion, death occurred a Practioner: To the best of my knowledge, death occurred at the time, date and place	t the time, date and place, and due to the	cause(s) and manner stated							

D 37142

1355 Piccard Drive, Suite 100, Rockville, Md. 20850

29d. Date signed (Month, Day, Year) May 6, 2011

DHMH 17 Rev 7/2009

State Registrar ess of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatu

M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sarah Frances Jackson 09:16 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HICOMICO ONIN SULA BIONN SAL150114 If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, Funeral 8. Date of Birth Birthplace (State or Foreign MD Country) 1 M 2 XF Months Days Min (Month, Day, Year) -26-1941 Hours Director 70 215-38-1825 Usual Residence of Decedent 28a-f show ms 23a or 28a-f shor must be notified at the Maryland 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Somerset Westover MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 31589 Charles Barnes Road 21871 USA death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Examiner Armed Forces?

1 Yes 2 No 0 by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 er than "natural", c SpeB,lack 1 Yes 2 X No Specify If Yes. Give 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry Je filed wn. ∼tal Hygiene. `⊶r than "p (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Somerset County Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Board of Education Secretary traumatic event, Be 17. Father's Name (First, Middle, Last) th and Mental F 18. Mother's Name (First, Middle, Maiden Surname) 2 Milbert Leatherbury Mary Dennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sof Health permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Ralph Jackson/Husband 31589 Charles Barnes Rd, Westover, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Ebenezer UM Cem 5-7-2011 Marumsco, MD Bennard Add San Feelity 917 W. Signature of Funeral Service Licensee Isabella St. Funeral Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Retween Immediate Cause (Final Onset and Death Physician/ henni disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Dav Pregnant at time of death 5 Other (specify) the detached g Unknown 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be Bacterial Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical Be completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospital: 2 No မ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 \sum Yes 2 \sum No. Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) HOOS6197 30. Name and addre of person who completed cause of death (Item 23a) (Type, Print) E. Cranull St 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

32. Registrar's Signature

9

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

		Please Type of State (r Print in Blac of Maryland / D				-		gible.			
	_	1 - State RegistAMEND#11perINF,5/16/11;	BMW,MbCb	Cert	ificate of L	Death	F	leg. No.	400	16448		
Physicia Medic		1. Decedent's Name (First, Middle, Last) Kam Chuen Ko					2. Date of Dea Month May 4	Day	1 Year	3. Time of Death 7:20 aM		
Examin		4a. Facility Name (if not institution, give street and nur	,		•	r Location of Death			ty of Death			
Funeral		Montgomery Hospice— Cas 5. Social Security Number 6. Sex	Rocks If Under 1 Year	7ille I If Under 24 Hrs.	8. Date of Birth		tgome:	ry place (State or Foreign				
Director	- 1	578-82-0638 1 ⅓ M 2 ☐ F Usual Residence of Decedent	Months Days	Hours Min.	Oct. 20		Coun					
28a-f shov	Director	10a. State 10b. County MD Montgomery	10c. City, Town		ville				1	0d. Inside City Limits		
is 23a or 3 nust be no	Funeral Di	10e. Street and Number 1004 Julian Place			10f. Zip Code 2085	52		10g. Citizen o USA		try?		
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	Armed Fo	2 🔀 No ve	lf \	as Decedent of H Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	ВІ	ce - Americ ack, White, 6 y: Asia 1	etc.		
than "natu he Medical	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Seconday (0-12) College (*	(Give kir life. DO	ent's Usual Occup nd of work done o NOT use retired)	ation during most of work	king	16b. Kind of		dustry			
Hygie other ent, ti	a	17. Father's Name (First, Middle, Last)	1 0	hef		18. Mother's Nam	ne (First, Middle, M	Resta.				
Mental narked natic ev	욘	Zuang Cai Ko					ian Chen					
alth and 27 is n er traum		19a. Informant's Name/Relationship (Type, Print) Ping Ko/Son	I			and Number or Rur View Ter		-		,		
nent of He ant: If iten ary or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of cemetery	Disposi , crema			Date ay 9,	20c. Location	- City or To	wn, State		
Departi Import any inj once,		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University BlvdW. Silver Spring. MD 20901										
ysician/		23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on earl mmediate Cause (Final disease or condition	caused the death. Do no ach line.							Approximate Interval Between Onset and Death		
Medical kaminer		resulting in death) Due to (or as a consequence of):										
de la companya de la	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.	(or as a consequence of	ŋ:								
hysician ar he burial-t	<u> </u>	resulting in death) Last Due to	(or as a consequence of	7):								
within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	_	in the past 12 months?	tcome of pregnancy Birth 2 Fetal death gnant at time of death nown		Ectopic pregnand Other (s <i>pecify</i>)	у			ate of delive	ry Day Year		
en signed by	≥	23e. Did tobacco use contribute to the c										
ate has be	Completed			· · · · · · · · · · · · · · · · · · ·			24a. Was ar autops perforr 1 \(\sum \) Yes	ned?		sy findings available npletion of cause of 2 No		
certific ector,	m	25. Was case referred to medical examiner?				ace of Death (Chec		u.	anio			
th. After this funeral di	cate: To	27. Manner of Death 1 Natural 5 Pending (Mon	of injury 28b. Tir	n, Day, Year) injury work?						·		
I Director.	Certificate	3 Suicide 6 Could not be 28e. Place	e of Injury - At home, farning, etc. (Specify)	n, street		755 2 2 110	28f. Location (Str City or Town		per or Rural	Route Number,		
n 24 hours le Funera bleted fille	Medical	29a. Certifier (Check only one) 12 Gertifying Physician: To the bound of the control of the bound only one) 12 Gertifying Nurse Practioner:	sis of examination and/or	investiga	ation, in my opinio	n, death occurred a	t the time, date and	d place, and di	ue to the cau	se(s) and manner stated.		
Somi		29b. Signature and title of certifier			29c. License		2	9d. Date signe	ed (Month, E			
		30. Name and address otherson who completed caus Bindu Joseph, MD 1355	se of death (Item 23a) (Ty 5 Piccard D		nt)			, ,				
State Registra			Registrar's Signature							-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 6449 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ MAY Day 2011 Year DONNA ROGE KENNEDY 2 10:45P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months July 26, 1951 1 □ M 2 🔀 F 59 New York **Director** 214-58-3173 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director Frederick MD Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 501 Prospect Blvd #A4 21701 United States or items hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 "natural", 1 ☐ Yes 2 X No Specify. If Yes, Give White 3 X Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sales Specialist Plumbing traumatic event, Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve any injury or other traumatic eve Henry R. Roge Florence Lulley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ryan Roge (Son) 501 Prospect Blvd, # A4, Frederick, MD 21701 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Metropolitan
Crematory 1 🗌 Burial 2 🗶 Cremation 3 🗆 Removal from State May 6, 2011 4 Donation 5 Other (Specify) Alexandria, Virginia Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home, 10 Eas Gaithersburg, 10 East Deer Park Drive, IRACY 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Probable Onset and Death Immediate Cause (Final Physician/ Intarction disease or condition resulting in death) Medical **Examiner** Ischemic if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last use as the burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? for Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No been signed by the a 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N page 2 has Hospital or Attending Physician: The certificate 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) မ 1 Tyes 2 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After 1 🖊 Natural 5 Pending injury 1 Yes 2 No within 24 hours after death To the Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) MDD 35267 MD

Registrar

DHMH 17 Rev 7/2009

State

74h St

Frederick, mo

400

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

asiano

Manuel

31. Date filed (Month, Day, Year)

MAY 0 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 6450 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DURWARD WALTER KETTELLS May 20 9ª 1 7:35 Medical P^{M} 4a. Facility Name (if not Institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Golden LivingCenter Frederick Frederick Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 □ F Feb. 16, Year 1914 215-14-2754 Months Days Hours Min Director 97 Connecticut Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 617 Grant Place 21702 U.S.A. within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 Never Married 2 Married Black, White, etc 2 Baltimore, Maryland 21215-0036 1 Yes If Yes, Give 2 No 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced WWII Specify: Year or Dates White Medical Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Parole & Probation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jesse C. Kettells Matilda Mierendorf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Kettells / Wife 617 Grant Place, Frederick, MD 21702 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 4 Donation 5 Dother (Specify) Olivet Cemetery 5/10/2011 Frederick, Maryland Signature of Funeral Ser 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. NORTH MARKET STREET, FREDERICK, 23a. Part 1. Enter the disease, or complicatione that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ATHERW SCLEROSIS Physician/ Onset and Death CORONARY Medical resulting in death) Due to (or as a consequence of): _xaminer COPID Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi been signed by the attending physician and should be detached for use as the himal-ther Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy his certificate had director, page performed? Yes 2 X No death? 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ၉ Other: 1 Tyes 2 **V** No 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Dear Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural s after decral Director: After hy the fu injury 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homici**d**e determined within 24 hours at To the Funeral D completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Countries Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 1041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK 21701 KAZMI. MM Toll 814

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 8, 2011 Eleanor H. Kramer 7:48 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Crofton Convalescent & Rehab Center Crofton Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**XX**F Days Hours June 10, ear 1918 Washington, D.C 579-16-4981 92 Director Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location with the Maryland must be notified at 10d. Inside City Limits **Funeral Director** 1 X Yes 2 No CT Hartford Manchester 10e. Street and Numbe 5 10f. Zip Code 10g. Citizen of What Country? 23a 91 Elm Street Apt. 213-C 06040 U.S.A. items 2 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ natural", or 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give 1943 Year or Dates. 1946 Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 XXWidowed 4 □ Divorced Specify: White er than "natur, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Sector other t Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve once. 2 Catherine J. Altorjer Herman E. Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Kramer/Son 91 Elm Street Apt. 213-C, Manchester, CT 06040 20a. Method of Disposition 20b. Place of Disposition (Name of First Lumeters Checker 1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State 05/11/2011 | Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home Jan 1. Ka 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition 7 mar Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) the burial-tran resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Day Pregnant at time of death
Unknown ned by the at detached for 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ perlipidemia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autons death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to pedical filled in by the funeral director, To Be 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No Accident Suicide Investigation Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title o 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SETAL MATTU 2401 Brandermill Blvd. Suite 220 Grambrills, MD 21054 31. Date filed (Month, Day, Year) MAY 10 2011 Registrar's Signatu

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar State of Maryland / Department of Health and Mental Hygiene Registrar									
Н	Dhusisia	/	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death									
	Physicia Medio		Robert Samuel Kenney Month 5 Day 4 Year 1720 M									
ng - 2	Examir	er	4a. Facility Name (if not institytion, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death									
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Norths Days Hours Min. 8. Date of Birth (Month, Day, Year) 1 North, Day, Year)									
			Usual Residence of Decedent									
	Iryland I-f sho ied at	Funeral Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits									
	he Ma or 28s notif	Dire	MD Wicomico Salisbury 1 □ Yes 2 ₺ No 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country?									
	with t	eral	5811 Homestead Street 21801 U.S.A.									
	death items ier.m	핕	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 14. Race - American Indian,									
36	after al", or xamir	d by	1 Never Married 2 Married 1 1 1 Yes 2 □ No If Yes, Give 1944 - 1 □ Yes 2 🗷 No Specify;									
9	hours natura lical E	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry									
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2	Hygier Hygier other t	Be C	9 animal control officer county & town government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surrame)									
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	17. Father's Name (First, Middle, Last) George W. Kenney 18. Mother's Name (First, Middle, Maiden Surname) Ruth Dickerson									
lary	should and N is ma aumat		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
≥	and 2. Health em 27 ther tr		Ruth M. Kenney (Wife) 5811 Homestead Street Salisbury, MD 21801									
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altin	mit. Pa bartme bortan r injury		4 Donation 5 Other (Specify) Springhill Memory Gardens Hebron, Maryland 21. Signature of Funeral Service Licencee 22. Name and Address of Facility Short Funeral Home									
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	nysician/ ∕ Medical Examiner		23a. Part / Ente the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death onset and Death Due to (or as a consequence of): Consecutive list as a consequence of the control of th									
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Division of Vital	r Atter ter deg rector	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 s	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	Noith To 1	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
	10 -		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
	カント		YOCKTSH VOHRA 910 EASTERN SHORE OR, SALISBURY, MD, 2184									
ţ	Stat Registra	e ir	31. Date filed (Month, Day, Year) 12. Registrar's Signature 13. Save									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 2011 Year David John Lewis May 11:25 aM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sanctuary at Holy Cross Montgomery Burtonsville Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 7, 1946 9. Birthplace (State or Foreign Country)
England **Funeral** Months 1 X M 2 D F 65 **Director** 578-88-0676 Usual Residence of Decedent show 10a. State 10b County the Maryland 10c. City. Town or Location notified at Director 10d. Inside City Limits 28a-f MD Silver Spring Montgomery 1 Tes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ed other than "natural", or items 23a o event, the Medical Examiner must be by Funeral with 13715 Old Columbia Pike 20904 England Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes Z No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Department of Health and Men Important: If item 27 is marke any injury or other traumatic John Lewis Betty Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13715 Old Columbia Pike, Silver Spring, MD 20904 Tara Lewis/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA permit. 22. Name and Address of Facility Francis J. Collins Funeral Home p00 University Blvd. W., Silver 21. Signature of Funeral Service Licenses Home Inc. ilver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ asta COLO YECRA Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that better the cause of t Examiner Due to (or as a consequence of). use as the burial-transi D that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant 9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician; The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending injury 1 Natural 2 Accident
3 Suicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 0069829 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith Are. enseen 31. Date filed (Month, Day, Year) State MAY 06 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ma∜°9 2011 0600 A Carroll Blaine Lusby, Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Calvert Memorial Hospital</u> Prince Frederick Calvert Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗐 M 2 🗆 F (Month, Day, Year Months Days Hours 220-16-8703 85 Mary Land Director Sept Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Calvert Solomons 1 🗌 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14235 N. Sedwick Ave. 20688 United States permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 XYes 2 If Yes, Give þ Baltimore, Maryland 21215-0036 res, Give 44-46 Year or Dates. 1 ☐ Yes 2 🙀 No Specify: white Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Drafting Engineer U.S. Government æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guy Anthony Lusby ည Virginia Beatrice Knott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 Southwest Ct. Lusby, MD 20657 Carroll B. Lusby, Jr. - son 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Funeral Service 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 KCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria Virginia 21. Signature of Funera Service Licensee 22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final set and Death Pnysician/ disease or condition resulting in death) Medical DI as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 SS IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No the g Unknown g Unknown Division of Vital Records, P.O. þ signed t Other significant conditions contributing to death but not result the underlying cause giver in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Yes Completed page 2 should 24a. Was an 24b. Were autopsy findings available To the Hospital or Attending Physician: The law has autopsy perform prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of De Th 1 X Natural 2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the leasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check 🗆 Certifying Nurse Practioner: To the best of thy knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signatur

31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

(Item 23a) (Type, Print)

pleted cause of death

32. Registr

State Registrar 31. Date filed (Month, Day, Year)

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JEAN

MANDA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar 16456 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mav Voar Joseph Wilmer Lee Medical 1:35 P M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 87 Stewart Drive, #304 Anne Arundel Edgewater 5. Social Security Number 6. Sex 14 M 2 D F 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Hours Month, Day, Director 218-36-6978 71 Maryland Usual Residence of Deceden iral", or items 23a or 28a-f show Examiner must be notified at 10a. State with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland | Anne Arundel Edgewater 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 87 Stewart Drive, #304 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 X Married Black, White, etc 1 ☐ Yes 2 🏋 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Completed 3 Divorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Salesman Plumbing & Heating Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Wilmer Ray Lee Edna Marie Collison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) G. Carol Lee/ Wife 23 Boulder Rd., Hanover, Pennsylvania 17331 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Mayo U.M.C. Cemetery 5/11/11 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 22. Name and Address of Facility George P. Kalas Funeral Home Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ phag once disease or condition mostas Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exami the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 JE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Month Yes 2 No the 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Qid tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autops certificate Yes the Hospital or Attending Physician: 25. Was case ref red to medical Be 26. Place of Death (Check only one) Hospital Other: မ 1 Tes No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) n 24 hours after death.

e Funeral Director: After the oleted filled in by the funeral Name of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 1 🗌 Yes 2 🔲 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one 29b. Signature and title of certifier e Werny 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Parkway

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) MAY 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last. 2. Date of Death 3. Time of Death Physician/ Month Day Year Michelle Andrea Ortiz Monney $a^{\,\mathsf{M}}$ 2011 Medical May 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 8. Date of Birth (Month, Day, April 15 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Year) 2011 1 M 2 X F Days Director 213-91-0506 Ŏ MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1

Yes 2 □ No MD P.GHyattsville 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 5404 Hamilton Street, #3 20781 USA items Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ō þ 12 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☑ Yes 2 ☐ No Specify: Honduran & If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced Specify: White Guatemalan Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Health and Mental Hygiene. tem 27 is marked other than other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) None None N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Derick Francisco Ortiz Mildred Lourdes Monney Artiga 19a. Informant's Name/Relationship (Type, Print) -Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5404 Hamilton Street, Mildred Lourdes Monney Artiga #3, Hyattsville, MD 20781 other item 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) of Heaven Cemetery Gate Silver Spring, 22. Name and Address of Facility rancis J. Collins Funeral 00 University Blvd. W., S 21. Signature of Funeral Service Licenses 1 Home Silver MD 20901 Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Er **Approximate** Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of) **Examiner** Partial Trisomy 5p, Partial Deletion of 5p Sequentially list conditions any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) P requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): use as the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Year Pregnant at time of death Day the detached Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Prematurity should t 1 Yes 2 No 3 Probably 4 Unknown been Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law page 2 certificate has autopsy performed death? within 24 hours are,
To the Funeral Director. After this 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 27 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work? Accident Investigation M 2 🗌 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D66134 May 3, 2011 hav 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Chrysanthe Gaitatzes, MD

State

Registrar

31. Date filed (Month, Day, Yea.

MAY 0 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 7:00A M 2011 22, D. McNair April Sadie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Villa Rosa Nursing Home Bowie If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 ☐ M 2 💢 F 83 9,1927 Washington, DC Director 577-36-1645 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h: County iral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 □ No Director Washington, DC DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20019 USA 4005 Anacostia Ave., N.E. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify þ Specify: 3 XWidowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DC Public Schools Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph E. Devoe Sadie Wells 2 19b Mailing Address (Street and Number or Riwal Route Number, City or Town, State, Zip Code)
1206 Castlewood Drive
Upper Marlboro, MD 20774 19a. Informant's Name/Relationship (Type. Print) Health tem 27 i Upper Marlboro, MD Aaron D. McNair/Son other Department of Her Important: If Item any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Mem. Park 4/28/11 Landover, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Austin Royster Funeral Home Cluntoco M00969 3821 14th Street, NW, Washington, DC 20011 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final JKS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Drewmia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed MITCH 1)0 that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 2□No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No thours after death.

Uneral Director: A
ely filled in by the fi death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one, and manner stated 29d. Date signed (Month, Day, Year) and title of dertifier 29c. License number 29b. Signature) 3 2 2 6

State Registrar 30. Name and address of pers

31. Date filed (Month, Day, Year)

Richard Feldman, MD

MAY 06 2011

8116 Goodluck Road #300, Lanham, MD

20706

on who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 0 If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Months Davs Hours Min. Feb. 27 Y91917 New York 94 **Director** 148-30-1802 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 72 hours after death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral U.S.A. 21620 8894 Center Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black White etc Yes 2 XNo Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify. "natural", 3X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Brielle Board and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) of Education Kindergarten Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ida Theresa Swenson Department of Health and Ment. Important: If item 27 is marked any injury or **** John G. Swenson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Miller (son) 8894 Center Lane Chestertown, MD. 21620 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kent Cremation 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 5/9/11 Smyrna, DE. 4 Donatton 5 Other (Specify) Name and Address of Facility Lena Funeral Home of Stephen L. Schaech 8 West Cross St. Galena, MD. 21635 M00510 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. OHENERS resulting in death) Last burialphysician the burial Physician/Medical P.O. Box 68760 attending ph for use as th IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death the 9 Unknown 9 Unknown s been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? Yes 2 No 1 Yes 2 🗌 No this certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2)KS No 1 Tes ၉ 12 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No injury 1XX Natural 5 Pending hours after death. neral Director: Aft d filled in by the fur Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) City or Town, State) within 24 hours a

To the Funeral D

completed filled i Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 20 D0045688 10 30. Name and address son who completed cause of death (Item 23a) (Type, Print) 21620 Gabrie Ci Chesicelaux 100 Rm 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G916 6/13/2011 JH. State of Maryland / Department of Health and Mental Hygiene 201 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 4, Charles W. McIlroy 2011 8:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Crofton Care & Rehab Crofton 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 ★ M 2 □ F 89 Hours Min Director 552-18-6685 Yrs California Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George's Bowie 1XXYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1603 Portland Lane 20716 USA Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. 1 XYes If Yes, Give 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates. 1945-73 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Msgt Drummer U.S. Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown McIlroy Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heidy A. Suit/Daughter 184 Narrow Lane, Falling Waters, WV 25419 20a. Method of Disposition 20b. Place of Disposition (Name of Department of I Important: If ite any injury or ot 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Arlington Nat 1 Cem. 8/04/2011 4 Donation 5 Other (Specify) Arlington, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ste disease or condition resulting in death) Cerebra Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated separate.) Examine attending physician and for use as the burial-transif that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day signed by the a d be detached for 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, cate has been signated by page 2 should to 2-No 3 Probably 4 Unknown 1 Yes Were autopsy findings available prior to completion of cause of autopsy perform Yes 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page death? Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature an 29d. Date signed (Month, Day, Year) D20108 5 3 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakesh Arora, 14300 Gallant Fox Lane, Bowie, MD 10 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Jane McAllister Month 05 11:101 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico isbi g. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country)
Set Virginia 1 🗆 M 2 🕱 F Months Hours Min (Month, Day, Year) 234-24-4308 88 Director West Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits or 28a-f sl notified 1 Yes 2 XNo Maryland Wicomico Salisbury ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 233 Dykes Road 21804 USA 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 X Married Yes 2 No Yes, Give 1 Yes 2 X No Specify: white "natural", 3 Widowed 4 Divorced Year or Dates. Navy nt of Health and Mental Hygiene.

If item 27 is marked other than "nature or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Phillip Showers Florence L. Uqlo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 233 Dykes Rd., Salisbury, MD 21804 Robert McAllister/spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place Eastern Shore of MD Veterans cemetery 1 X Burial 2 Cremation 3 Removal from State Important: I any injury o 4 Donation 5 Other (Specify) 5/10/2011 Hurlock, MD 21. Signature of Funeral Service Lio Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one car ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediat cause. Enter Underlying Due to for as a consuluence of nding physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 proofths?

1 Yes 2 No Dav Year Pregnant at time of death 9 Unknown 9 Unknown has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2/SINO Completed 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director; After this certificate 1 Yes 2 Yes 7 Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence HOSPIGE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 No Investigation 6 Could not be 2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Codtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifie 29c. License number D0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21022 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 17.30PM FRANK, NEWMAN BERT. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hoseitai Carroll Westminster If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. NJ g. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 XM 2 □ F 2 Mg th, Pay 5 2 59 218-52-1448 **Director** Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carroll 1 🗆 Yes 2 🏻 No MD Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 447 John Owings Rd. 21158 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Paper Mill Millwright 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည David A. Newman Edith Delawder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 447 John Owings Rd., Westminster, MD 21158 Ivy Smink-sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State South Carroll Crem 4-18-11 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home Signature of Funeral Service Licensi 254 E. Main St., Westminster, MD 21157 nona 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ Tro disease or condition resulting in death) MONU Medical Due to (or as a consequence of). Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iii)ury Due to (or as a consequence of). that the death certificate be executed and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death Yes 2 No 1 Yes 2 L 9 Unknown 9 Unknown be detached signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director, After this certificat. has been si completed filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician; The law autopsy performed' 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO မ 1 Department 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatur title of certifie 29d. Date signed (Month, Day, Year) WIL 16,20 212 ddress of person who completed cause of death (Item 23a) (Type, Print) AMANDEEP 31. Date filed (Month, Day, Year, 32. Redistrar's Signature State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		State Registrar			Ce	rtificate of L	Death	Re	g. No.	-	16464
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Director		578-36-5736 Usual Residence of Deceder			Yrs.	Months Days	Hours Min.	2-24-1	^(ear) 917	Mary	y)
"natural", or items 23a or 28a-f show sdical Examiner must be notified at	tor	10a. State 10b. Co	unty	10c. Cit	ty, Town or Lo	ocation				10	d. Inside City Limits
of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	Funeral Director	Maryland Pr	ince Geo	rge Bra	ındywi						1 X Yes 2 □ No
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Department of Health a Important: If item 27 is any injury or other training.		21. Signature of Funeral Serv	vice Licensee	Λ		2. Name and Addres		. , , ,		, , , , , ,	7 - 4114
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withi To th	-	29b. Signature and title of ce	rtifier			29c. License	854	5 1	d. Date signer	d (Month, Da	2.811
32		30. Name and codress of per	rson who completed c	ause of death (Item	23a) (Type, I	Print) LD LINS	LEWY.	82 (U)	H DOAK	ELA	d. 200
Stat	e	31. Date filed (Month, Day, Ye	ear) 32	. Registrar's Signa	ture	4	, , 5, 5 /	00/	و حرب	/	
Registra	ar	MAY	1 1 2011	Sinewa	A. A	sake!					
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 04 may Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Healthcarel nwote a Shington Habers 8. Date of Birth If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last birthday) (Month, Day, **Funeral** Months Min. 1 □ M 2 🔯 F Hours Year 1929 Virginia 82 Director 212-32-9132 Jan. Usual Residence of Decedent permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other trainmant. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Smithsburg 1 Yes 2 K No Washington Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 21783 20908 Twin Springs Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2
No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Josie May Brown Jackson Melvin Freeman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20908 Twin Springs Dr., Smithsburg, MD 21783 19a. Informant's Name/Relationship (Type, Print) Ronald Phillips / Grandson 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May 7^{ate} 2011 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland Resthaven Crematory 21. Signature of Pureral Sovice Licensee Resthaven Fulferal Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease of complications that caused shock, or heart failure. Its only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit Dronan resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Mellitus, Diabetes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 (No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2 XNo 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1.X Natural 5 Pending work' 1 🗆 Yes 2 🗆 No М Accident Investigation within 24 hours after deatl To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 333 Mill Street, Huberstown, MD21748

Registrar DHMH 17 Rev 7/2009

State

backs

egistrar's Signature

Surbara Naden-Blucher, CRNP

2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 4, Year Patnaik Prakash 2011 3:30 am M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery 8105 Begonia Way Gaithersburg Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 6. Sex 1 → M 2 □ F 7. Age (In vrs. last birthday) Hours June 23 70 India **Director** 222-40-6735 1940 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Montgomery Gaithersburg 1 🗆 Yes 🏞 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 8105 Begonia Way 20879 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 K Married Maryland 21215-0036 1 ☐ Yes XX No Specify: Indian If Yes, Give Year or Dates Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Nuclear Regulatory 5+^{College (1-4 or 5+)} Elementary/Seconday (0-12) Senior Nuclear Engineer Commission Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) ပ Prananath Patnaik Manjari Patnaik 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2322 Seventh Avenue, New York, New York 10 19a. Informant's Name/Relationship (Type, Print) Mala Perna - daughter 10030 Baltimore, 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Stauffer Crematory 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-7-2011 Frederick, Maryland 22. Name and Address of Facility . Signafure of Funeral Service Lipensee Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Petween Onset and Death Immediate Cause (Final Ph, si i n disease or condition Chronic Congestive Heart failure Medical resulting in death) Due to (or as a consequence of). Examiner Myocardial infarction Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying sician and burial-transit Cause (Disease or iinjury that initiated events Arteriosclerotic cardiovascular disease Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death been signed by the should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by chronic right sided pleural effusions 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an history coronary artery bypass grafts After this certificate has autopsy perform Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending injury Accident Investigation after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0055522 May 6, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen ROAD Silver Spring, MARYLAND 20910 H GERARD 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or L Loys Station Park Frederick							Death	Death 4c. County of Death Frederick				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1								thplace (State or n Michigan untry)				
any	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation			-				10d. Inside City Limits	
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	ł	Alicia Pasciak ,			Place of Disportenatory or o	osition (Na	me of ceme	etery,		ck, MD	20c. Location	- City or	Town, State	
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ivisi or Att after de Direct	Certification:	2 Accident Investign 3 Suicide 6 Could determ	not be 28e. Place o	f Injury - At ho			y, office bu	ilding, etc.	36	or Town, St 00 Old Fred	treet and Numb tate) erick Road, T	er or Ru	ral Route Number, City	
To the Hospital within 24 hours: To the Funeral completely filled	Medical C		sician: To the best of iner:On the basis of and manner stat	examination ar	ge, death occ nd/or investig	urred at th	ne time, date	e and plac death occ	ce, and du curred at th	e to the cause ne time, date a	e(s) and manne and place, and	r as stat due to th	ed. e cause(s)	
1. × 1. §	Me	29b. Signature and title of certifier	and mariner stat			29	9c. License O.C.M				29d. Date sign May 5, 20		nth, Day, Year)	
		30. Name and address of person w Ana Rubio MD. Assis	ho completed cause		23a) 000 W. Ba	ltimore	Street F	Raltimore	e MD 2	21223				
10+1VA	tate	31. Date filed (Month, Day, Year)	0011 32. R/gi	strar's Signatu		all			J, 141D 2					
Regis	_	PA 11 A 13 541	111111111111111111111111111111111111111	Deran	4.4 16.400	THE PERSON NAMED IN								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician/ 2:35 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Golden Living Center-Westminster 8. Date of Birth (Month, Pay, . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8 1 🗷 M 2 🗆 F Months 21328 762 Director Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 shculd 1 e filed within 72 hours after death with the Maryland Department of Health an Mental Hygiene. Important: If item 27 is narried other than "natural", or items 23a or 28a-f show any injury or other traun atte event, the Medical Examiner must be notified at any injury or other traun. 10a. State 10b. County 10c. City, Town or Location Director Maryland Carroll County Hampstead 1 X Yes 2 No 10f. Zip Code 10a. Citizen of What Country? United States Funeral 21074 3800 Normandy Drive, 3D Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☑ Yes 2 ☐ No 1946If Yes, Give
Year or Dates. 1947 Black, White, etc. 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: white Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Verizon Computer Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mildred Fredrich Henry A. Plantholt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3800 Normandy Drive, 3D Hampstead, Maryland 21074 Mary Catherine Plantholt / wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State May 9, 1 X Burial 2 Cremation 3 Pemoval from State Finksburg, Maryland Evergreen Mem. Gdns. 2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Eline Funeral Home . Signature of Funeral Service Licensee Hampstead, Maryland 21074 934 South Main Street M00741 Levener 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death 1 Yes 2 No ed by the a ☐ Unknown Division of Vital Records, P.O. signed t Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? After this certificate has page 2 performed' 1 ☐ Yes 2 ☐ No Yes 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatore and title of certifier 10+1 VA and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Barbara S. Patterson 3, 9:00 p^{M} 2Ö11 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico 8220 Robinhood Drive Salisbury 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Hours 06/07/1933 Country 301-28-4203 77 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a, State Director 1 Yes 2 No Salisbury Maryland Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö "natural", or items 23a or edical Examiner must be Funeral 21804 USA 8220 Robinhood Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 11. Marital Status 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: white 3 X Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry than Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. Domestic Homemaker permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, # Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ၉ Jeanne F. Cashell James J. Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8220 Robinhood Dr., Salisbury, MD 21804 Lucinda Gosling/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) 5/10/2011 Raymond, OH Raymond Cemetery 21. Signature of Fuperal Service Licen 22 Horio Ways Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the bunal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death signed by the aid be detached for a 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy death? 1 Yes 2 No certificate Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) director, Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral directions. 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death 28d. Describe how injury occurred Certificate: work? 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29b. Signature and title of certifier D0029168 com 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 5

DIVISION ST.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Katherine Month 02:15 A M May 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Ballimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 1, 1951 **Funeral** 9. Birthplace (State or Foreign Days 1 🗆 M 2 🔀 F Months Hours Min. North Carolina Director 214-60-7549 Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No DE Sussex Seaford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17 E. High Street 19973 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ♣ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 1 Tes 2 No "natural". 3 Widowed 4 Divorced Completed white Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be file I Health and Mental H Item 27 is marked of ပ္ William D. Humphrey Mildred Joyce Shackelford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Jack Walter Price (Husband) 17 E. High Street Seaford, DE20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State ò ☐ Burial 2 X Cremation 3 ☐ Removal from State injuny o 4 Donation 5 Other (Specify) Crematory of Delmarva05-12-2011 Delmar, Delaware 22. Name and Address of Facility
Short Funeral Home
13 East Grove Street 21. Signature of Funeral Service Licensee 'n Short Vewell 2 Delmar, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Palmonary Hypertension disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Stage COPD Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to lor as a consequence of burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be Division of Vital 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? After Natural 5 Pending
Investigation 1 Yes 2 🗌 No Accident 24 hours after death Funeral Director: completed filled in by the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the l within 2 To the f only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 113 444 616 4 MD 2011 TO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S Greene St. Baltimure MD 21201 NICHOLAS GOEHNER 22 31. Date filed (Month, Day, Year) State 09 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Geter 11:20 P M Rogers, Jr. May 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Montgomery Gaithersburg 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours (Month, Day, Vashington.DC 578-18-4222 Director 88 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or idical Examiner must be i 415 Russell Avenue Apt. 904 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 X Yes 2 No 1946 -Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 1948 White Specify: Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dentist Dental Practice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked of traumatic even ဂ္ Richard G. Rogers, Sr. Gladys Corrin Department of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tr Ricahrd G. Rogers, III/Son 8200 Wisconsin Ave. #606 Bethesda, MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 M Burial 2 Cremation 3 Removal from State Park Lawn Cemetery Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature (Funeral Service Licen DeVol Funeral Home 22. Name and Address of Facility M01315 2222 Wisconsin Ave., N.W. Washington, DC 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ilure to thrive disease or condition Medical resulting in death) Examiner 4 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical as IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months? Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic interestitual lun 1 Yes 2 No 3 Probably 4 Unknown pertension. Ostean 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page somal atrial fibri performed? Yes 2 death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) 2 🖪 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🗷 Natural work 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Id Ribert Brischlack US. 04115 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 RUSSELL AVENUL GALTHERSBURG, MD

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month,

Maryland 21215-0036

Baltimore,

Box 68760

Records,

Division of Vital

2. Registrar's Signature

14. ROBERT BIRSCHBACH, WIN.

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			State Registrar	ate of Maryland / [artment of F tificate of L			giene Reg. No	21111	16472		
	Physicia Medic		1. Decedent's Name (First, Middle, Last) James Arthur					2. Date of Dea Month 5	ath Da	2011 Year	3. Time of Death		
	Examir	er	4a. Facility Name (if not institution, give street Golden Living Co				Location of Death		4c	. County of Death Frede	rick		
	Funeral Director		5. Social Security Number 6. Sex 1 ☑ M	7. Age (In yrs. last birth	nday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 9 I		9. Birthplace (State or Foreign Country) WV			
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	with the M 23a or 28 ist be not	eral Dir	10e. Street and Number 110 Burgess Hill			10f. Zip Code	702		_	tizen of What Cou			
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces? Yes 2 XNo Yes, Give ar or Dates.	If	/as Decedent of H Yes, specify Cuba ☐ Yes 2 🛣 No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White			
Maryland 21215-0036	hin 72 houn ne. Ithan "natur e Medical	Completed	15. Decedent's Educatio (Specify only highest grade cor Elementary/Seconday (0-12)	npleted) ollege (1-4 or 5+)	(Give k life. DC	ent's Usual Occup ind of work done of NOT use retired)	during most of work	ng		ind of Business Ir	dustry		
and 2	be filed wit ental Hygie ked other ic event, th	To Be C	17. Father's Name (First, Middle, Last) Carl E. Ramsey	e (First, Middle, Inknowr	Maiden	ity gov Surname)	't						
, Mary	d 2 should ealth and M 1 27 is mar er traumati	19a. Informant's Name/Relationship (Type, Print) Carl A. Ramsey (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 2100 Wayside Dr. #1C, Frederick											
Baltimore,	Page 1 an ment of He ant: If iten ury or oth		20a. Method of D isposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	1/201	20c. Location - City or Town, State LL Frederick, MD								
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	ath certificate be execut attending physician and for use as the burial-trai	ਯੂ	resulting in death) Last	Due to (or as a consequence of	1).						•		
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate twithin 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the two forms.	by Physician/Medic	in the past 12 months?	yes, outcome of pregnancy Live Birth 2 Fetal death Pregnant at time of death Unknown		Ectopic pregnand Other (specify)	y		23d. Date of delivery Month Day Year				
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Division of Vital Records,	sician: The law rec s certificate has bee irector, page 2 sho	Completed		24a. Was an 24b. Were autops autopsy prior to comperformed? 1 □ Yes 2 ☑ No 1 □ Yes 2									
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ion	tending death. tor; Aftu the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		jury		? Yes 2 \(\sum \text{No} \)						
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	To the Hos within 24 hα To the Fun completed	Medical	only one) 3 Certifying Nurse Prac	to the best of my knowledge, d the basis of examination and/or tioner: To the best of my knowle	investi	gation, in my opinio	n, death occurred at a time, data and Uso	the time, date a	nd place	, and due to the ca	use(s) and manner stated.		
9	o o o o o o		29b. Signature and title of certifier	m MD			number 5839/	- 1		te signed (<i>Month</i> ,	*		
	4		30. Name and address of person who completed the AZ	12, MD, 80	ype, Pr	TollH	ouse 1	Ive, F	red	Perich,	11 MD 21701		
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signature	1	backel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAYnth Day 201 Year 6 RAMSBURG 6:25A HILDA GERTRUDE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, March 9 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏲 F Months Days Hours Min. 1926 Mary Land 85 Director 213-26-1025 March Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d, Inside City Limits Director 1 🗌 Yes 2 🏝 No Thurmont Maryland Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 11227 Putman Road United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Was Decede... _ Armed Forces? ¹ ☐ Yes 2 No Black, White, etc.
White 1 Never Married 2 Married <u>ک</u> Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", 3 X Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Garment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ William Washington Gue Clara Elise Cutsail Page 1 and 2 should ment of Health and M 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Thurmont, Maryland 21788 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 11227 Putman Road Wayne E. Ramsburg / Son Date 10, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 10 2011 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) Frederick, Maryland Resthaven Mem Gardens 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Tuperal Service Licensee Frederick, Maryland 21702 1621 Opossumtown Pike 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate erval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): ≟xaminer COPD exacerbation Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director. After this certificate has k completed filled in by the funeral director, page 2 s autopsy performed? prior to completion of cause of death? 2 No Yes 2 N 1 Yes of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ည 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 5/6/11 8001.00Q 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sathyabama Naidu 400 Frederick, mi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State b. SERAL

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7^{Day} Physician/ 2011 Marguerite G. Riker 6:10A M May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Brooke Grove Rehab and Nursing Sandy Spring 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Ye Nov 26 1 M 2 X F Months Min. 1922 88 Maryland Director 214-16-1687 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director Sandy Spring 1 Yes 2 No Md. Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20860 United States 17715 Dominion Drive filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married q Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏿 No Specify. White Specify. "natural" 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be Marguerite C. Appleby Grove George F. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20882 . Page 1 and 2 sl ment of Health a tant: If item 27 is 24109 Woodfield School Road, Laytonsville, Md. Cindy Baruch / POA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🗷 Burial 2 🗌 Cremation 3 🗆 Removal from State Mt. Olivet Cemetery 5/10/11 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home 20882 O. Box 5038, Laytonsville, 23a. Part 1. Enter the disease, or complications that car shock, or heart failure. List only one cause on each disease, or complications that caused the death. Do not enter the mode of dying, as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/) Medical resulting in death) a consequence of Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending housing and sician and burial-transit Exam Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 9 Unknown ntributing to death but not resulting in the underlying cause given in Part I Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? \$ Records, 1 ☐ Yes 2 ♣No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: work? 5 Pending Division 2 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title 30. Name and addres 15 Revistrar's Signature 31. Date filed (Monti State 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Box 68760

P.O.

of Vital

3396	11	Please Type or Print in Black Indelible Ink. Ensure A	III Copies	Are Legi		16675						
Rutkoske, I		State of Maryland / Department of Health and M I-For State Certificate of Death Registrar										
Physicia lical Exami	n/	Decedent's Name (First, Middle,Last)			ay Year	3. Time of Death 1140 hrs						
ilcai Exaiiii	161	Felix Rutkoske, III。 4a. Facility Name (if not institution, give street and number) 1559 Middleneck Road Warwick		May 5, 2011	4c. County of Deat	h						
Funeral Director		222-74-3526 123M 2 F 23 Yrs. Months Days F	Under 24Hrs. Hours Min.	8. Date of Birth()	MM/DD/YYYY) 9. Bi 1988 Forei Co	rthplace (State or gn puntry) Delawa:						
Aaryland 28a-f show any 1 at once	7	Usual Residence of Decedent 10a. State				10d. Inside City Limits 1 Yes 2 No						
the Maryla is or 28s-f	Director	10e. Street and Number 9 Susie Ct. 10f. Zip Code 1 9709		10g.	Citizen of What Cou USA	untry?						
er death with , or items 23 r must be no	The part of the pa											
1 6 n 72 hours afte an "natural" ical Examine												
21215-0036 und be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Com	12 Farmer 17. Father's Name (First, Middle, Last) Felix Rutkoske, Jr. Farmer 18. Mother's Name (First, Middle, Maiden Surname) Karen Jeandell										
MD Z7		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Print) 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State Print) 9 Susie Ct., Middletown, DE. 19709										
Saltimore, bernit. Pages 1 an Department of Hea Important: If iten injury or other tr		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Forest Cemetery 5-11-11 Middlet										
Depart Depart Import injury	1	21. Signature of Euneral Service Department of Euneral Service Daniel H. Daniel S. & Hutchison funeral H. 1212 N. Broad St. Middletown,										
Physician Medical Examiner	3	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such failure. List only one cause on each line. Immediate Cause (Final disease a. Contact Gunshot Wound of Head	h as cardiac or re	espiratory arrest	, shock, or heart	Approximate Interval Between Onset and Death						
7	Į.	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):										
ted Insit	Examine	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):										
be executed be executed sician and urial - transit	평	d. UNPENDED AMENDED										
l of Vital Keconds, P.O. BOX 66/60, ing Physician: The law requires that the death certificate be ex After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	Ectopic pregnanc	су	23d. Date of delive Month	ry Day Year						
s that the d gned by the	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I.			o the cause of death?						
ol VIGAL RECOLUS, ag Physician: The law require ther this certificate has been si neral director, page 2 should b	Completed			24a. Was an autopsy perform	prior to death?							
certifica rector, pa	BeC	examiner?	Death (Check on									
nding Phys th. r: After this												
DIVISION pital or Attendi uns after death. eral Director: /	ertifica	The state of Death St										
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deal and manner stated.	ath occurred at t	the time, date an	s) and manner as sta d place, and due to 29d. Date signed (M	the cause(s)						
	ž	O.C.M.E. May 6, 201										
4		30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Str 31. Date filed (Month, Day, Year) 32. Registrar's Signature	reet, Baltimo	ore, MD 2122	23							

DHMH 17 Rev 1/2001 OCME 2006

Registrar

parks ORIGINAL

amended item# 7 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gloria Delores Rideout 5 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Wicomico Slow Salisbury Rehabilitation & Nursing Ctr 7. Age (In yrs. %ast birthday) If Under g. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Months Days Hours Min 5-2-1929 Country) - 82 Director 218-24-6021 dDUsual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD Dorchester Rhodesdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4919 Maiden Forest Road 21659 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 \square Never Married 2 \square Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Sped lack 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Line Worker B&G Pickle Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Granville Pinder Grace Chase 9000h 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Railroad Rd, Hurlock, MD 21643 Sherwood Pinder/Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Veteran's Cem 5-9-2011 Hurlock, MD Signature I E neral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 917 W. Isabella St. Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due f or as diconsequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day Pregnant at time of death 1 ☐ Yes 2 ☐ g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred work?
1 Yes 2 No 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) UKC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robins Dilliam m. 31. Date filed (Month, Day, Year) State 0 5 2011 Registrar

wchd-te-5/10/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month Physician/ 2017 PM 2225 Brenda Jouce Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗶 F Months Hours ,1940 Washington, 70 577-56-8664 Director Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ral", or items 23a o Examiner must be Funeral 2016 Cradock Street 20905 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: nan "natural", Medical Exan If Yes, Give Year or Dates Specify Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "1 life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the of Property Management Veteran's Affairs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Minnie S. Leak Baxter L. Quick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is a any injury or other traumonce. 2016 Cradock Street, Silver Spring, Maryland 20905 Barrington Smith, spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🗴 Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 5/6/2011 Brentwood. Maryland 4 ☐ Donation 5 ☐ Other (Specify) MO1102 22. Name and Address of Facility Sumple Tribute 21. Signature of Funeral Service Licensee Kouse 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Renal failure disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Severe Sepsis Sequentially list conditions. Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events -transit requires that the death certificate be executed Obstructive Jaundice Due to (or as a consequence of resulting in death) Last physician at the burialburial-Physician/Medical Pancreatic Cancer Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Deep Venous Thrombosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an After this certificate has page 2 death? the Hospital or Attending Physician: Thin 24 hours after death.

the Funeral Director: After this certified 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 5 Pending 1 Yes 2 No Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide eted filled in by determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature 29d. Date signed (Month. Day, Year, May 4, 2011 055148 completed cause of death (Item zoa) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20910

Registrar DHMH 17 Rev 7/2009

State

Delroy Anglin.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 03. Physician/ Olivia Grace Shao 2011 6:08p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's 10304 Bristolwood Court Laurel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Country Maryland Days 1 🗆 M 2 🕅 1 Min Month Day Year, 216-87-3863 Director 1 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 1 No Maryland Prince George's Laurel 5 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 10304 Bristolwood Court 20708 U.S.A should be filed within 72 hours after death and Mental Hygiene.

is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Asian Year or Dates injury or other traumatic event, the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nicole V. Pavlos Jonathan Y. Shao 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau 10304 Bristolwood Court, Laurel, Maryland 20708 Nicole V. Shao - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Cedar Hill Cemetery 05/07/2011 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, MOIS64 21. Signature of Funeral Service License 11800 New Hampshire Ave., Silver Spring, MD 20904 Karn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Phylician respiratory disease or condition resulting in death) cut 2 Medical Due to (or as a consequence of): Examiner 1tiple Sequentially list conditions if any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a d be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ obnormal brain development, 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed SEI ZUEZ disorder VENTILAtor de pendques 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an Was an autopsy performed? page 2 s within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, pag To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

State Registrar address of person who completed cause of death (Item 23a) (Type, Print)

Dona Leskuski, D.O.,

MAY 0 6 2011

31. Date filed (Month, Day, Year)

14 666665

9200 Basil Court, Suite 200, Largo, Maryland 20774

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Day May 2011 Betty Jane Shotwell 10:18 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 621 California Avenue Anne Arundel Rose Haven Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Days Months Hours Min. 06-12-1944 Wash. D.C. Director 215-64-5119 66 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Anne Arundel Rose Haven 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 621 California Avenue 20714 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. or than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes Give 3 Widowed 4 Divorced Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Poole Flora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5993 Autumn Spell, Elkridge, Eugene C. Shotwell, MD 21075 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) So. Memorial Gardens 05-10-2011 Dunkirk, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ANCER Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events resulting in death) Last as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death nse If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 200 prior to completion of cause of death? 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6

State Registrar

DHMH 17 Rev 7/2009

dew

32. Registra s Signature

110 Hospital Road, Prince Frederick, MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

M.D.

John Barth,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Amend Registrar	led#13p	St perFH	tate of FCHD	Marylan KS 5/	id / Depa 10 / 11 Cer	artmen tificate	t of H	ealth a eath	and M	/lental Hy	giene Reg. N	201	16480
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Medic	al	Frances 4a. Facility Name (if r			and numb	er)		4b Ciby	Town or	Location o	of Death	May		c. County of Deat	6:20p M
Examin	er	Golden Li		-		01)		4D. Oity,		ederi		Frede			
Funeral Director		5. Social Security Nur 437-26-27	02	6. Sex 1	ast <i>birthday)</i> Yrs.	If Under Months	1 Year Days	If Under Hours		8. Date of Bir Feb 15	th 1922	9. Bir 2 Miss	thplace (State or Foreign		
nd how at	ř	Usual Residence of D 10a. State	Decedent 10b. County			10c. Cit	y, Town or Loc	ation				-			10d. Inside City Limits
// Aarylar Ba-f s tified	ecto	PA	Adam	S		В	iglerv:	i11e							1 ☐ Yes 2X No
with the N 23a or 2 ust be no	Funeral Director	10e. Street and Number 490 Wind:		ook Ro	oad			10f. Zip	Code 1730	7			10g. Citizen of What Country? USA		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Marrie 3 🏝 Widowed 4		ried 1	/as Decedermed Force Yes 2 Yes, Give tear or Date	? □ X No	If Yes, specify Cuban, Mexican, Puerto					o Rican, etc.) Black, White			
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nd 2 shoulealth and m 27 is miler traumi		19a. Informant's Nan J ean Proct			,		19b. Mailin 490	g Address Wind	(Street a	nd Numbe Brook	r or Rura Roa	ad, Big	er, City o. lerv	r Town, State, Zij ille, PA	A 17307
Page 1 ar ment of He ant: If iter ury or oth		20a. Method of Dispo 1 ☐ Burial 2 X 4 ☐ Donation	Cremation	3 Remo	oval from S	tata C	Place of Disposemetery, crem cederic	atory or of k Cre	her place emat c	ory 5	/5/2		Fre	ocation - City or	MD
permit. Departi		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Hom 1621 Opossumtown Pike, Frederick, M													
Physician/		23a. Part 1. Enter the shock, or heart Immediate Cause (Fi disease or condition	failure. List o inal	nly one call	co on each	line						or respiratory a		45E	Approximate Interval Between Onset and Death
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2	onths?	1 4	Live Bi	nt at time of c	al death 3 🗀	Ectopic p		/				23d. Date of de Month	livery Day Year
uires that th signed by lid be detac	þ	Part II. Other signific	ant conditio	ns contribu	ting to dea	th but not res	ulting in the u	nderlying c	ause give	en in Part I					the cause of death?
The law requate has bee page 2 shou	Completed											24a. Was auto perfe 1 \(\sum \) Yes	psy ormed?	prior to death?	topsy findings available completion of cause of
sian: T ertifica ctor, p	Be C	25. Was case referred examiner?	to medical						26. Pla	ce of Deat	h (Check		-/	101 101	7
Physic this ce al dire	일	1 Yes 2	No	Hospit	1 ∐ In		ER/Outpatien			4 LANNU				6 ☐ Other (Spec	cify)
tending lasth. tor: After the funer	Certificate:	1 Natural 2 Accident 3 Suicide	5 Pending	g jation		Day, Year)	28b. Time of injury	М			No	28d. Describe			
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the Hosp hin 24 ho the Fune mpleted fi	Medical	(Check 2/ only one) 3	Medical E Certifying	xaminer: Or	n the basis	of examination	and/or investi	gation, in n eath occurr	y opinior ed at the	n, death oc time, date	curred at	the time, date	and place ne cause(e, and due to the (s) and manner as	cause(s) and manner stated. stated.
7 w 7 00		29b. Signature and tit	le of certifier		MO			29c.	License 4	number 195	-1			ate signed (Monti	
0		30. Name and address Sibte Ka:	zmi MD		Toll	House	Avenue		deri	ck, l	Mary	land 21	701	-	
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DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03181 DNNE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, Year, 8/20/1954 219-64-9816 Yrs 56 **Director** Marvland Usual Residence of Decedent 28a-f show 10c. City, Town or Location If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 🗶 No Anne Arundel Edgewater Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21037 USA 117 River Road and 2 should be filed within 72 hours after death Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Truck Driver Giant Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Blanche Carolyn Curry George Sonnenleiter, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah A. Sonnenleiter/ Wife 117 River Road, Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite cemetery, crematory or other place 1 Durial 2 X Cremation 3 Removal from State Kalas Crematory 5/10/11 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Teath Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 1 Yes 2 L 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performed' 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: After this certific
mpleted filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 1 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

complete only one 29b. Signature and title of certifier 29d. Date 1187 a 80. Name and address of person use of death (Efense ENGLIEUT 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				aryland / Depa			Mental Hyg	jiene	1 21 00				
			State Registrar	Cer	tificate of l	Death	F	Reg. No.	16482				
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea		3. Time of Death				
	Medic		David Steir	<u> </u>			April	30, 2011	12:11 p M				
	Examin	er	4a. Facility Name (if not institution, give street and number) 12940 Hopetown Lane		4b. City, Town, o Ocean	r Location of Death City		4c. County of De					
	Funeral			(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		irthplace (State or Foreign				
	Director		218-30-0929	1 \times M 2 \square F 93 Yrs. Months Days Hours Min. 12/04/1917 New New Manual Property 12/04/1917									
	d ow it	_	10d. Inside City Limits										
	rylan i-fsh ieda	10a. State 10b. County 10c. City, Town or Location 10c. City 10c. Ci											
	e Ma r 28a notif	Ë	10e. Street and Number	Ocean Ci	10f. Zip Code				1 Yes 2 X No				
	with th s 23a o ust be	Funeral Director	12940 Hopetown Lane		218	42		10g. Citizen of What C USA	Country?				
	death item		11. Marital Status 12. Was Decedent E- Armed Forces?		Vas Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Am					
36	after al", or	d by	1 Never Married 2 Married 1 X Yes 2 If Yes, Give 7	Married 1 🖾 Yes 2 🗆 No									
9	hours hatura ical E	Completed	15. Decedent's Education		lent's Usual Occup	ation		16h Kind of Busines	s Industry				
215	n 72 e. an "r Med	ф		(Specify only highest grade completed) (Give kind of work done during most of working									
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pu	filed tal Hy d oth event	o Be	17. Father's Name (First, Middle, Last)				ne (First, Middle, N	Maiden Surname)					
yla	uld be I Meni narke	욘	Hyman Stein Celia Dinkelas 19a. Informant's Name/Relationship (Type, Print) Susan Williams/step-daughter Susan Williams/step-daughter Celia Dinkelas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Company of Company o										
Baltimore, Maryland 21215-0036	d 2 sho alth and 27 is r er traun		Susan Williams/step-daughte	er 606 P	g Address (Street a ine Bluf:	and Number or Rui f Rd.,Sal	al Route Number, isbury,	City or Town, State, 2 Maryland	(ip Code) 21804				
ore,	1 and of Hear		20a. Method of Disposition	20b. Place of Dispos	sition (Name of	20)	Date	20c. Location - City of	or Town, State				
<u><u>ä</u></u>	Page nent ant: It ury or	1 Burial 2 🗷 Cremation 3 Removal from State cemetery, crematory or other place) 5 Unique of the place Salisbury Crematory 05 04 2011 Salisbury Cremator											
Balt	The state of the s												
			23a. Part 1. Enter the disease, or communations that caused shock, or heart failure. List only one cause on each line.	the death. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate				
-	nysician/	8 6	Immediate Cause (Final disease or condition	mode mi	ii. Con	onam (2 Lens	DISPACO	Interval Between Onset and Death				
	Medical Examiner	resulting in death) a. Due to (or as a consequence of):											
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87	tifica ng ph as th	Me	IF FEMALE:						<u> </u>				
9 ×	tendi r use	ian/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnanc	у		23d. Date of d	·				
B	the at the at thed fo	Physician/M	1	time of death 5	Other (specify)		-	Month	Day Year				
Ö.	hat th ed by detac	by Ph	Part II. Other significant conditions contributing to death but	t not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute t	o the cause of death?				
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ord	v requ	Completed					24a. Was ar	24b. Were a	utopsy findings available				
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of	ng Phy fter thi ineral (27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 1 Natural 5 Pending 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred 1 Yes 2 No										
<u>o</u>	tendii leath. :or, A: the f.	iţics											
Division of Vital Records, P.O. Box 687	al or At after c Direct d in by			Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route No. 12 City or Town, State)									
_	To the Hospital or Attending Physician: The law requires that the death certific within 24 hourst later death. To the Funeral Director. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examily one) 3 Certifying Nurse Practioner: To the basis of examiners on the basis of examiners of the basis of the basis of the basis of the basis of examiners of the basis of the	amination and/or investi	igation, in my opinio	n, death occurred a	t the time, date and	d place, and due to the	cause(s) and manner stated.				
	To the comp	2	29b. Signature and title of certifier	cas of the fallowiedge, d	29c. License			9d. Date signed (Mon					
	2.		m m	7	D:	54127		5/3/11					
	50		30. Name and address of person who completed cause of de-			-1		, , , , , ,					
	EVA		Hon DAMS MO, 100	3 Power S	t., Sau	sbury, r	AID 918	304					
	Stat Registra		31. Date filed (Month, Day, Year) 32. Fegistrar MAY 0 6 2011	's Signature	well								

			State of Maryland / De	partment of Health and N	Mental Hyg	iene 20	16483					
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death Reg. No.								
	Physicia		HELEN MARIE SHAMER		2. Date of Deat Month	Day 2011	3. Time of Death					
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	1 04	4c. County of Death	12:30 A M					
1			Coastal Hospica Of the lake	Salisbury		Wicom						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min	8. Date of Birth	O Diete	place (Ctate or Familia)					
	Director		216-32-1145 The Market of Decedent The Market The Market Of Decedent The Market T	Meridio Sayo Flodio Mini.	AUG. 22,	1936	ntry) MARYLAND					
	and show at	to 10a. State 10b. County 10c. City, Town or Location										
	//aryla 8a-f s tified	Director	MD WORCESTER OCEAN PI	IES			1X Yes 2 ☐ No					
	a or 2 be no	٥	10e. Street and Number	10f. Zip Code	-1	l0g. Citizen of What Cou	intry?					
	h with	Funeral	22 COTTONWOOD COURT	21811		USA						
	r deat		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 Married 12. Was Decedent Ever in U.S. 1 □ Yes 2 No	 Was Decedent of Hispanic Origin? (Spends of Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White						
936	s after al", o Exam	g p	3 Widowed 4 Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2X No Specify:		Specify: WHI	TE.					
2-0	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho Aedical Examiner must be notified at	Completed by	15. Decedent's Education 16a. De	cedent's Usual Occupation		16b. Kind of Business In						
21	nin 72 ne. han " e Me	mo Mo	Elementary/Seconday (0-12) College (1-4 or 5+)	ve kind of work done during most of work DO NOT use retired)	king							
2	d within Hygiene. ther than nt, the N	a	12 HOI 17. Father's Name (First, Middle, Last)	1EMAKER		OWN HOME						
Baltimore, Maryland 21215-0036	be filed ental Hy rked oth ic event	10	HARRY WILGAR SR.		ne (First, Middle, M LE CORRON	*						
ary	should be file and Mental ' 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Run			Code)					
Σ	1 and 2 s of Health item 27 i			COTTONWOOD CT., OCE	EAN PINES	s, MD 21811						
ore	gelan tofH Ifite or oth			position (Name of rematory or other place)	Date	20c. Location - City or T	own, State					
<u>tim</u>	Description of the position of											
Ba	permit. Departn Importa any inju		21. Sign ture of Funeral Service Licentee	22. Name and Address of Facility HASTINGS FUNERAL HO	OME, SELE	BYVILLE, DE						
			23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.		_		Approximate Interval Between					
partie.	Physician/ Medical			einoma with b	Frain Me	etestases !	Onset and Death					
	Examiner		Due to (or as a consequence of):									
		ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):									
	uted Id ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c									
	execian an	I Ex	resulting in death) Last Due to (or as a consequence of):									
09	ate be executed ohysician and the burial-transit	dical	d									
687	ertifica ding p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy									
ŏ	atten for us	iciar	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	very Day Year					
B	the de by the ached	hysi	9 Unknown									
<u>G</u>	that gned k	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?					
ds,	quire; en siç buld b	ted			1 ☐ Ye	es 2 🗌 No 3 🔀 Pro	bably 4 🗆 Unknown					
COL	law re las be 2 sh	Completed by			24a. Was an autops	y prior to co	ppsy findings available empletion of cause of					
Be	: The law cate has ; page 2 s				perform 1 \sum Yes 2		2 🗷 No					
ita I	hysician: T nis certifica I director, p	Be c	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Inpution 2 FR/Output	26. Place of Death (Check			110-2-					
of <	y Physer this eral di	e: To	27. Manner of Death 28a. Date of injury 28b. Time	of 28c. Injury at	ome 5 Resider 28d. Describe hove	nce 6 🔀 Other (Specif w injury occurred) HOSPICE					
on (ading rath. rr. Afte	icat	1 ⊠ Natural 5 □ Pending (Month, Day, Year) injur 2 □ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No								
Division of Vital Records, P.O. Box 687	r Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Str. City or Town,	reet and Number or Rura . State)	l Route Number,					
Ö	pital o		20 O M. A. M. Co. of the Distriction To black of									
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours afferd eath. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 ► Certifying Physician: To the best of my knowledge, dear control of the basis of examination and/or involved only one) 3 □ Certifying Nurse Practioner: To the best of my knowledge	estigation, in my opinion, death occurred a	it the time, date and	d place, and due to the ca	use(s) and manner stated					
	To the within To the comp	2	29b. Signature and title of certifier	29c. License number		9d. Date signed (Month,						
			Lugar h Bellow M. &	D 29505		04-30	-2011					
	TC		30. Name and address of person who completed cause of death (Item 23a) (Type	· ·								
			GREGORIO M. BELLOSO; 5302 (WI) 31. Date filed (Month, Day, Year) 32. Significant Signature	NABERRY DR., SALI	SBURY,	MD 218	01					
	Stat Registra	e ir		have								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

11-03349		pe or Print in Black Ir				16181
Edwin Thomas Sm	1- For State	State of Maryland / Depa Cea	artment of Health an <i>rtificate of Death</i>	d Mental Hygiene	Reg. No.	33304
Physician/ Medical Examine				2. Date of Month May 3	Death Day Year , 2011	3. Time of Death 1310 hrs
	4a. Facility Name (if not institute Nanticoke River	ion, give street and number)	4b. City, Town, or Bivalve	Location of Death	4c. County of Deat Wicomico	
Funeral Director	5. Social Security Number 2013-54-7435	6. Sex 7. Age (In yrs. I	ast birthday) If Under 1 Yea Months Day Yrs.		of Birth(MM/DD/YYYY) 9. Bi Forei C	
nd See.	Usual Residence of Decedent 10a. State 10b. Count	SMICO TOC. City.	, Town or Location			10d. Inside City Limits 1 Yes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number	SKIN RD	10f. Zip Code	-	10g. Citizen of What Cou	untry?
er death with the constitution of the constitu	11. Marital Status 1 Never Married 2	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No	If Yes, specify Cubar	spanic Origin? (Specify Yes on, Mexican, Puerto Rican, etc.	.) White, etc.	rican Indian, Black,
and 2 1215-0036 and 2 should be filed within 72 hours after feath and Mental Hygiene. ttem 27 is marked other than "natural", traumatic event, the Medical Examiner To Be Completed by	45 December 15 to a time 15	ivorced If Yes, Give Yeer or Dates; eccify only highest grade completed) College (1-4 or 5+)	1 Yes 2 No. 16a Decedent's Usual Occupa during most of working life	tion (Give kind of work done	Specify: Washington 16b. Kind of Business.	/Industry
215-0036 se filed within 72 hour and Hygiene. the Other than "naturent, the Medical Exament, the Medical Exament Be Completed	17. Father's Name (First, Midd	e, Last)	PIPEFITTE	R. 18.Mother's Name (First, Mid	PUNSIN	16
21214 hould be fill and Mental F is marked infic event, I	19a. Informant's Name/Relatio		19b. Mailing Address (Street	GLADYS et and Number or Rural Route		_
nore, MD ages I and 2 sho nt of Health and it: If item 27 is other traumati	20a. Method of Disposition		Place of Disposition (Name of ce crematory or other place)	metery, Date	20c. Location - City o	r Town, State
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with) Department of Health and Mental Hygiene. Important: If item 77 is marked other th injury or other traumatic event, the Med	4 Donation 5 Other 21. Signature of Funeral Service	Specify: 511 Specify: 511 Specify: 511	LISBUDY CHEMITO 22. Name and Addres Mrssick FO	124 5-10-20 s of Facility	ORIX GI BIVAL	
Physician Medical	23a. Patri. Enter the disease, failure. List only one cau.	or complications that caused the death se on each line.	. Do not enter the mode of dying	such as cardiac or respirator		Approximate Interval Between Onset and Death
Examiner	or condition resulting in death) Sequentially list conditions,					
xaminer.	if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury man initiated events resulting in death). Las	D				
	i	d	8a-f,per me,g9	15 5-25-11 sm		
Division of Vital Records, P.O. Box 68760, ital or attending Physician: The law requires that the death certificate be executed are deed. After this certificate has been signed by the attending physician and lled in by the funeral director, page 2 should be detached for use as the burial - trans ertification: To Be Completed by Physician/Medical E	FFEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 L	the 23c. If yes, outcome of preg 1 Live birth 4 Pregnant at time of de	nancy 2 Fetal death 3	Ectopic pregnancy	23d. Date of delive Month	ry Day Year
P.O. B es that the d igned by the detached	5	itions contributing to death but not r	resulting in the underlying cause	3	Did tobacco use contribute to	
Division of Vital Records, P.O. rate of extending Physician: The law requires that the anterface of the control of the control of the charter of the chis certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by Pertification:						utopsy findings available completion of cause of 'es 2 No
Vital Recysician: The list certificate director, page	25. Was case referred to medi examiner?	Hospital 1 Inpatient 2	26.Place ER/Outpatient 3 DOA	of Death (Check only one) Other	5 Residence 6 ✔ Othe	er: Scene
on of Vit anding Physic tth. r: After this he funeral diris	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Inju		cribe how injury occurred	
Division (ital or Attending urs after death. ral Director: Af illed in by the fun ertification	2 Accident Inv 3 Suicide 6 X Co	estigation II 3-3-11	ome, farm, street, factory, office I		tion (Street and Number or R wn, State) Nantiok (Live, Md.	ural Route Number, City

Divisior
To the Hospital or Attend
within 24 hours after death
To the Funeral Director:
completely filled in by the

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Registrar's Signature ORIGINAL

(Specify) Found in river

and manner stated.

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Ling Li, MD

Medical

State Registrar May 4, 2011

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are, Legible.

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene, For AMEND 29D per PHY State of Maryland State 5/10/2011 AACO HEALTH DEPT CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Frances L. Thompson 2011 April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Woodward Estates Bowie If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🏻 F Hours 86 203-12-2380 Director Usual Residence of Decedent or 28a-f show e notified at 10b. County 10c. City, Town or Location 10a. State Director MD Prince George's Upper Marlboro 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 "natural", or items 23a or Funeral 20774 17713 Oueen Anne Road USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11 Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed oe filed with.
Mental Hygiene.
of other than "natu.
t, the Medical Ey 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Analyst National Security 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic ever 2 Alfred M. Butz Amelia Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. Fred A. Thompson II/Son 17713 Queen Anne Road, Upper Marlboro, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Maryland Veterans Cem. 05/10/2011 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ reduce disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Box 68760 the as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) in the past 12 months? or Month led by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed k 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Records, Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsv performed' Yes 2 No Hospital or Attending Physician: 1
 24 hours after death.
 Funeral Director. After this certifica completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No ☐ Accider☐ Suicide Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29d. Date signed (Month, Day, Year) May 3, 2011 29b. Signature and title of certifier oleted cause of death (Item 23a) (Type, Print) 0/1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

MAY 1 0 2011

31. Date filed (Month, Day, Year)

State

Registrar

ORIGINAL

32. Registrar's Signature

3. Time of Death

g. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

death?

Year

1 ☐ Yes 2X No

Pennsylvania

White

11:10 PM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 20^{Year} May 3 Zachary Michael 11:30 a^M Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice-Casey House Montgomery Rockville Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 6, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 - F 045-80-1226 Yrs **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be martituded. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12821 Bushey Drive 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced SpecifiWhite 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Scientist Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wayne Stanley Upton, Jr. Barbara Mary Lawler

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

19a. Informant's Name/Relationship (Type, Print)

4 Donation 5 Other (Specify)

21. Signature of Funeral Service Licensee

20a. Method of Disposition

Prudence Avery Upton/Wife

1 🗌 Burial 2 🖾 Cremation 3 🗎 Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. Coleman, MD

MAY 06 2011

31. Date filed (Month, Day, Year)

Ph.sii.n Medical **Examiner**

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death.

To the Funeral Director: After this certificate has been signe completed filled in by the funeral director, page 2 should be o

Division of Vital Records, P.O. Box 68760

j	21. Signature of Funeral Service Licensee	Jodan	22. Name : Franc 500 Un	and Address of Facility is J. Collins iversity Blvd	Funera	l Home Inc. ilver Sprin	g, MD 20901		
5 6	23a. Part 1. Inter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition	cations that caused the death. Do cause on each line. Hevatobiliary	o not enter the mo	ode of dying, such as cardiac			Approximate Interval Between Onset and Death		
	resulting in death)	Due to (or as a consequence					-		
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Disease or iinjury	Due to (or as a consequence							
dical Exa	that initiated events resulting in death) Last								
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23d. Date of de Month	delivery Day Year						
ted by Pł	Part II. Other significant conditions con	tributing to death but not resulting	g in the underlying	g cause given in Part I.		obacco use contribute to	to the cause of death? Probably 4 Unknown		
Comple						prior to death?	topsy findings available completion of cause of		
Be	25. Was case referred to medical examiner?			26. Place of Death (Chec	k only one)				
10	1 ☐ Yes 2X No	ospital: 1	Outpatient 3 🗌 I	DOA Other: 4 Nursing H	ome 5 Resid	HOSDI dence 6 Other (Spec	ce :ify)		
	27. Manner of Death T Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year) 28b	. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe h	ow injury occurred			
Medical Certificate:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Ru City or Town, State)								
Medic	(Check 2 Medical Examine	sian: To the best of my knowledge er: On the basis of examination and Practioner: To the best of my kno	l/or investigation, i	n my opinion, death occurred a	at the time, date a	nd place, and due to the	cause(s) and manner stated		
	29b. Signature and title of certifier		29	9c. License number		29d. Date signed (Monti	h, Day, Year)		

D37142

1355 Piccard Drive, Rockville, MD 20850

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

May 2011

12821 Bushey Drive, Silver Spring, MD 20906

Date

20c. Location - City or Town, State

Alexandria, VA

May 3, 2011

State

Registrar

D

MARINAP, BUSABETA

			For State Registrar		State of	Marylaı		oartmen e <i>rtificate</i>			and M		gienę Reg. No	CUI		16488
	Physicia	n/	1. Decedent's Name (First Elizabeth		rdrin							2. Date of Dea	Da	y 204	ear	3. Time of Death W.487M
E.e	Medic Examin		4a. Facility Name (if not ins			er)		4b. City,	Town, or	Location o	of Death	771		. County of	Death /	10 NO
, 4			BAUTING PS 5. Social Security Number	MACH DA			AL CA	If Under	1 Year	EN If Under	24 Hrs.	8. Date of Birt		MME		ace (State or Foreign
	Funeral Director		195–18–6989) 1 🗆	M 2 X F	85	Yrs.	Months	Days	Hours	Min.	12/12/1		Ir	Count ndia	na
	and show dat	tor	Tour Glaco	County			ity, Town or l	ocation.							10	d. Inside City Limits
	e Mary r 28a-f notifie	Director	MD P1	rince Ge	eorge's	BC	wie	10f. Zip	Code				10- 0	tizen of Wha	t Court	1 Yes XX No
	with th s 23a o ust be	Funeral	6103 Sutter	rs Place	:				0720				US.		it Oour	
10	r death or items uiner m	by Fun	11. Marital Status 1 ☐ Never Married 2		2. Was Decede Armed Force 1 Yes 2	es?_	.S. 13	. Was Deced If Yes, spec				ify Yes or No- lican, etc.)		14. Race Black, \		
0036	within 72 hours after death with the Maryland jiene. 9r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Specify: Who Spec									Whit	e				
215-(י 72 hol an "nat Medica											Schools				
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Vita	nysiciar iis certil directo	To Be	examiner? 1 Yes 2 No	<u> </u>	spital:	patient 2	☐ ER/Outpat	ent 3 🗆 D	Othe	ar.	ath (Check ursing Hor	ne 5 🗆 Resi	dence (6 🗌 Other (Specify	
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visio	r Atten ter deal irector: I by the	Certificate:	3 Suicide 6 4 Homicide		28e. Place of building	f Injury - At h						28f. Location (S			or Rural	Route Number,
Ö	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach	Medical C	29a. Certifier 1 2 Co	ertifying Physic	ian: To the bes	at of my know	wledge, deat	h occured at	the time,	date and	place, and	due to the ca	use(s) a	nd manner a	as state	d.
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	Sta		31. Date filed (Month, Day	10 -	32. Aeg	gistrar's Sign	ature	by the	1	1,						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 201°1 Sigrid N. Whitney 11:20 A^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 2417 Belair Dr. Bowie Prince George's Social Security Number 6. Sex Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🗗 F Months Days Hours Min (Month, Day Year) 1y 6, 1925 Director 578-44-3911 86 Puerto Rico Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD XX Yes 2 No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20715 USA 2417 Belair Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black White etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Specify: White Puerto Rican Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Hostess Hospitality Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Arthur Nemcik Maria Antonia Davis permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2417 Belair Dr., Zulma E. Henneberger/Daughter Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 🛣 Burial 2 □ Cremation 3 □ Removal from State Metro Crematory 5/10/2011 4 Donation 5 Other (Specify) Baltimore, MD Signature of Funeral Se 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23at Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physici_n CANZER NUG disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that leitisted events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a d be detached f Unknown Part II. **Other significant condition**s contributing to death but net resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe certificate Yes 2 Yes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 🗌 Yes Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 \square Pending 2 🗌 No Accident Investigation 24 hours after deat Funeral Director; filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one within To the 29b. Signat of certi 29d. Date signed (Month, Day, Year)

Registrar

34

State

30. Name and address of person

31. Date filed (Mor

Registrar's Signat

23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month Day 04:00 M 2011 Medical Name (if not institution, give street and number County of Death **Examiner** ed ENTE 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, **Funeral** Month, Day, Year) Wasnington. 1 X M 2 □ F Days 220-02-0783 Director 43 Usual Residence of Decedent items 23a or 28a-f show 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 x No Maryland Anne Arundel Edgewater 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21037 130 Valley View Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. Be Completed by 1 Never Married 2 Married Yes 2 X No Yes, Give 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) HVAC Service Steamfitter 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) မ Helen Chase Ward John Bovan Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 Valley View Ave., Edgewater, MD 21037 Nancy Layne/ Fiance Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Mt. Harmony Cemetery 5/14/11 Owings, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Will Stee Licensee 21, Signatu 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Bac teremia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day 1 ☐ Yes 2 ☐ Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 thinknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 은 1 Depatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No atural 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 10 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

Amend 24a per med cert 6916 6/7/11 dk

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 8:00 A M 5 Gladys B. Wells May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Worcester Atlantic General Hospital Rerlin 8. Date of Birth
(Month, Day, Year)
Feb. 25, 1922 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Min. Hours 1 🗆 M 2 🖾 F Mary Land Director 215-18-4909 89 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Snow Hill 1 🗌 Yes 2 🏻 No Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21863 U.S.A. 6433 Snow Hill Road hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces 1 Never Married 2 Married ģ ☐ Yes 2 🔀 No 215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give Specify: white Completed 3 X Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 72 Elementary/Seconday (0-12) College (1-4 or 5+) Bank Teller Banking 12 and Mental Hygie is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hazel Bradford Richard Harmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Snow Hill, MD 21863 6631 McCabes Corner Rd. Important: If item 27 Billie Dee Wells (Niece) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Page 1 ₹ 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State permit. Page Department Snow Hill, Maryland 05-09-2011 4 Donation 5 Other (Specify) Whatcoat Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility.
Short Funeral Home 19940 Delmar, DE 13 East Grove Street 23a. Part 1. Inter the disease, a polication is that the ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus Final Dementa Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical pe that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş The law requires Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 XN certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification placed filled in by the funeral director, I Vital 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier **Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centifying Nurse Practionar To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centifying Nurse Practionar To the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) a Unit of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centifying Nurse Practionary To the basis of examination and/or investigation, in my opinion to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centifying Nurse Practionary To the basis of examination and/or investigation, in my opinion to the basis of examination and/or investigation, in my opinion to the basis of examination and/or investigation, in my opinion to the basis of examination and/or investigation, in my opinion to the basis of examination and/or investigation, in my opinion to the basis of examination and/or investigation, in my opinion to the basis of examination and/or investigation, in my opinion to the basis of examination and/or investigation, in my opinion to the basis of examination and/or investigation, in my opinion to the basis of examination and/or investigation and of the basis of examination and/or investigation and or investigation an (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0050826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Na 3 work En ola 9733 Her VR way Drive Belin MD 74811 31. Date fied (Month, Day, Year) State Registrar

#

1922

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Earle Henry Young 20T1 4. 10:13 A M May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3824 Winchester Lane Prince George's Bowie 9. Birthplace (State or Foreign Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min Yrs **Director** Maryland 214-09-0447 90 Sep. 1920 Usual Residence of Decedent show or 28a-f shov notified at 10a. State the Maryland 10c. City, Town or Location 10d. Inside City Limits Director XX Yes 2 No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ms 23a or must be r Funeral 3824 Winchester Lane 20715 USA "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ¥ Widowed 4 □ Divorced Completed Year or Dates. Unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) WSSC Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen T. Groves/ Daughter <u>5420 Lakeford Lane Bowie, MD 20720</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Baltfire reawas him ton 4 ☐ Donation 5 ☐ Other (Specify) 5/11/11 Laurel, MD <u>Crematory</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home P. 7 16000 Annapolis Road Bowie, MD_20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease Coronary disease or condition years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the aid be detached for 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 10 3 Probably 4 Unknown 1 Yes Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an , page 2 autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No funeral director, 26. Place of Death (Check only one) Be Hospital: Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending Investigation Accident the ∴ Accider
 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical 29a. Certifier 1 🚅 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Mon

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BOUNE

14300 Gallant For

distrar's Signature

M. 7 .

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle. Last) 2 Date of Death 3. Time of Death Physician/ Month 4:15 PM Zevallos Ortiz de Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimor Medica Mary land Center 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 06/30/1944 Peru 1 □ M 2 🔯 F **Director** 118-82-6001 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 🗌 Yes 2 💢 No Frederick Adamstown 10g. Citizen of What Country? 10e. Street and Number Funeral items 23a United States 21710 2748 Bill Dorsey Blvd. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 14. Race - American Indian Black, White, etc. Examiner 1 Never Married 2 Married "natural", or 2 Baltimore, Maryland 21215-0036 1 ¥ Yes 2 □ No Specify: Peruvian If Yes, Give Year or Dates. Specify: Hispanic 3

Widowed 4 □ Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry filed within 72 at Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) health care self-employed home health 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental h Eloisa Ramirez Zerobio Coracuillo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s of Health a item 27 i 2748 Bill Dorsey Blvd., Adamstown, MD 21710 Patricia Robson / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1
Department of
Important: If it
any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crematory 5/19/11 Winfield, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home) aduelle 106 E. Church St., Frederick, MD 21701 MO1222 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph, ician/ Daverimme Medical Di to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 - Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy
☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: _2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 27. Manger of Death (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident
3 Suicide Investigation 6 Could not be filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) May 17,201 1043445976 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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31. Date filed (Month, Day, Year,

MAY 24 2011

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32. Registrar's Signature

5. Greene St. Baltimore.

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Physicia		Registrar 1. Decedent's Name (First, Middle,L	ast)	00/1///	outo or Dear			2. Date of Dea			3. Time of Death
Medical Exami		Dawaun Christoph						Month May 14, 2			0406 hrs
*		4a. Facility Name (if not institution, g Johns Hopkins Hospital	ive street and number)		4b. City, Baltii		cation of Death		4c. County of	f Death N/A	
Funeral	4	<u> </u>	Sex 7. Age (In yrs. last b			If Under 24Hrs.	8. Date of Bir	th (MM/DD/YYYY)	9. Birth	
Director		214-23-5397	M 2 F	22	Yrs. Monti	s Days	Hours Min.	Feb. 16	6, 1989	Foreign Coun	Maryland
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th with tems 2.	Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ev Armed Forces?	/	13. Was Deced If Yes, spec	ent of Hispan fy Cuban, Me	nic Origin? (Sp exican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race - White		n Indian, Black,
her dea			1 Yes 2 1/ ed If Yes, Give Year	No	1 Yes 2	No sp	pecify:		Specify:	Blac	k
ours af	ğ	15. Decedent's Education (Specify	or Dates:	eted) 16a	a. Decedent's Usual during most of wo	Occupation	(Give kind of w		16b. Kind of Bus		
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21215-0036 and be filed within 7 Mental Hygiene. marked other than e event, the Medica	Be	Carl Jackson						I. And			
MD 2'd 2 should at and Me and	2	19a. Informant's Name/Relationship Catherine R. Daniels			9b. Mailing Addres						Zip Code) Land 21234
e, M and 2 Health item 2	ł	20a. Method of Disposition		20b. Place	of Disposition (Na	me of cernete		Date	20c. Location -		
TOF		1 Burial 2 Cremation 3		1	atory or other place Hill Ce:	•	5/28	3/2011	Brookly	m, N	Maryland
latti rmit. I spartma sports jury o	MD N/A Baltimore 106. Zirp Code 10g. Citizen of What US 10g. Zirp Code 10g. Zirp Cod										
Physician	4	23a. Part I. Enter the disease, or cor	onlications that caused the	e death Do					yland 2120 est shock or bea		Approximate Interval
/Medical		failure. List only one cause on						,,			Between Onset and Death
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be execution are urial - 1	gig	UNPENDED [AMENDED				•				
8766 ificate	Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome 1 Live birth	of pregnanc	y Fetal death	3 E	Ectopic pregna	ncv	23d. Date of o	deliv e ry Da	y Year
Box 68760, re death certificate be execut the attending physician and ned for use as the burial - tra	Physician/Medical E	past 12 months? 1 Yes 2 No 9 Unknow	4 Pregnant at tim	ne of death	5 Other (Spe	_					
O. BC	Phy	Part II. Other significant conditions	9 Unknown	ut not resulti	ing in the underlying	cause giver	n in Part I.	23e. Did to	obacco use contrib	oute to th	e cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by I led in by the funeral director, page 2 should be detacht	d b							1 Yes	s 2 No 3	Probal	bly 4 Unknown
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n of Vi ding Physi After this funeral din	일	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b		28c. Injury at	t Work?	28d. Describe	how injury occurre		
ion trendin leath. for: A	ation	1 Natural 5 Pending 2 Accident Investiga	May 14, 2011	' 03	05 hrs	1 Yes	2 ✔ No	Subject sho	t		
Divis I or As after of I Directed in by	Certification	3 Suicide 6 Could no	ot be 28e. Place of Injury		farm, street, factor	, office buildi		or Town, S	State)		Route Number, City
Tospita 4 hours Sunera		4 Homicide	cian; To the best of my ki		eath occurred at the	time date a		•	Marble Hall Ro		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical		er:On the basis of examinand manner stated.								
H 3 H 3	ž	29b. Signature and title of certifier	140011	120	29	c. License nu			29d. Date signe		h, Day, Year)
		(wor Val	lengest	1		O.C.M.E			May 14, 20	17	
5		 Name and address of person wh Victor Weedn MD JD 	o completed cause of deal Assistant Medical E		900 W. Baltii	nore Stree	et, Baltimo	re, MD 2122	23		
St		31. Date filed (Month, Day, Year)	3. Registrar's	Signature	parker						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death John Quincy Adams Physician/ May 17 Day 2011 9:30 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore Social Security Number 8. Date of Birth (Month, Day, Year) Nov 7, 1930 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs g. Birthplace (State or Foreign **Funeral** Days Hours 1 XXM 2 🗆 F 090-24-9102 80 New York Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at be filed within 72 hours after death with the Maryland ental Hygiene. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4004 Hickory Avenue 21211 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 WNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 XX Divorced Specify: White Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry should be filed within 72 h h and Mental Hygiene. It is marked other than "r (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Stationary Steam Engineer General Mills Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ Charles Francis Adams Lois Wipple 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra John Quincy Adams (Grandson) 6710 Magnolia Lane Fort Myers, Florida 33966 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Oaklawn Memorial Gardens 5/27/11 Gettysburg, PA 22. Name and Address of Facility Burgee Henss—Seitz Funeral Home 3631 Falls Road Balto, MD 212 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Physician disease or condition resulting in death) metustatic melanom nou to Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and tran resulting in death) Last Due to (or as a consequence of). physician as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pi IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year 1 ☐ Yes ∠ ☐ Unknown Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1405P15E ၉ 1 Inpatient 2 Inpatient 3 Inpa 4 Nursing Home 5 Residence 6 Other (Specify this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending nours after death.

neral Director: Af
filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours a To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the sest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0007063 Name and address of person who completed cause of death (Item 23a) (Type, Print) charles 6701 State 24 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20 Virgie Adele Adams 127 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 7. Age (In yrs. last birthday Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 ី F Months Days Hours Country) 1279/1935 216-34-4384 75 Yrs. **Director** MD Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director traumatic event, the Medical Examiner must be notified 1 Tes 2 No MD Anne Arundel Glen Burnie dams, Virais 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral marked other than "natural", or items 23a USA 212 St. James Drive 21061 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify If Yes, Give 3 X Widowed 4 □ Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1.2 College (1-4 or 5+) Washington Human Resources Associate Savings Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F ပ Elmer E. Hinternesch Carrie E. Hissy 1 and 2 should be of Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 St. James Drive Glen Burnie, MD 21061 Mrs. Charlene Ledford/ Daughter or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or ot 1 Burial 2XX remation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 5/23/2011 Glen Burnie, MD 21. Signature o Funeral Servic Vicensee 22. Name and Address of Facility Singleton Funeral & Cremation M01220 Services, PA 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition ev.a Onset and Death End Physician/ tag Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician and sthe burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? ğ Day Pregnant at time of death ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b been signe should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed Were autopsy findings available prior to completion of cause of death?

1
Yes 2
No 24a. Was an page 2 s autopsy Yes 2 1 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death Certificate: . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work?
1 Yes 2 No 5 \square Pending injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location /Street and Number or Rural Route Number. determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 2011 completed cause of death (Item 23a) Type, Print) me and address of person who pita 20161 1 32. Registrans Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Wear DU M OHN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) PA 1 M 2 D F 1 (Month, Day, Ye3) 8 218-36-1765 72 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he material once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Pasadena Anne Arundel 1 Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8210 Doby Lane 21122 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates, 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Brick Layer 2+ Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John W. Adams, Sr. Marie Mikoni 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy Adams - Daughter 8210 Doby Lane, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🗀 Removal from State Oak Lawn Cemetery 5-24-2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature Funeral Service Licensee 22. Name and Address of Facility Bradley-Ashton Funeral Home 2H/ 2134 Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Onset and Death NCREAT Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 2 No Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: thin 24 hours after death. completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number peted cause of death (Item 23a) (Type, Name and address of person who cor 6 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra 6498 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day 18, Karin I. Allen May 2011 10:36 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 7807 Winterberry Place Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min 297-38-9745 70 Director September 1, 1940 Germany Usual Residence of Decedent death with the Maryland 10b. County show 10a. State 10c City Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f sho Director 1 Tyes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 7807 Winterberry Place Germany Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race*- American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: \$ White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Interior Design/ nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Office Manager / Activist permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Goetzke Irmgard Klepsig ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Allen Lee / Daughter 47315 Westwood Place, Potomac Falls, Virginia 20165 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20c. Location - City or Town, State 20a. Method of Disposition v 20 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Bethesda, Maryland Crematorium, Inc. 22, Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Mariand 2081/-3501 21. Signature of Funeral Service Licenses Inseletter M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive Heart Failure 1 Year disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 20 Years Hypertension Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nunsciouenne of The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760 signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s performed? Yes 2 No certificate 1 □ Yes 1 ☐Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Certification: To this : After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural Injury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D0057896 May 19, 2011 ause of death (Item 23a) (Type, Print) 30. Name and address of person who completed 10215 Fernwood Road, #100, Bethesda, Maryland 20817 M.D. David W. Hirshfield

DHMH 17 Rev 1/2001

State Registrar

11-03595	
Ricky Bellamy	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ricky Bellamy	1- For State Registrar	State	of Marylar		artment of <i>rtificate of</i>		and	Menta	al Hyg		Reg. No.	2011	16499
Physician/	1. Decedent's Name		t)							Date of Dea Month	Day	Year	3. Time of Death 1552 hrs
Medical Examiner	Ricky L. 4a. Facility Name (it		e street and num	ber)	14	b. City, To	vn. or Lo	ocation of		May 12, 2		c. County of Death	
		eneral Hospita		,		Baltimo						N	1/A
Funeral	5. Social Security N	lumber 6. Se	ex 7	Age (In yrs. la	ast birthday)	If Under	1 Year Days	If Under 2	24Hrs. Min.	8. Date of B	irth(MM	/DD/YYYY) 9. Bir Foreig	
Director	216-80-6		M 2 F	51	Yrs		Days	Tiodis		Nov. 8	, 195		untMaryland
Any	Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Locati	on				-			10d. Inside City Limits
	MD		N/A	Balt	timore								1 Yes 2 No
Aaryland 28a-f show 1 at once. ector	10e. Street and Nur	mber				10f. Zip C	ode				10g. Cit	izen of What Cou	ntry?
3a or optified	716 East	North A					212					USA	
r death with the Maryland or items 23s or 23s-f sh must be notified at onc Funeral Director	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.											can Indian, Black,	
fter de 17, or i	3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 No specify: Specify: Blace										ck		
natural?	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15b. Kind of Business/Inc.										ndustry		
36 in 72 h han "r ilical E	Elementary/Seco	Elementary/Secondary (0-12) College (1-4 or 5+)										Private	Industry
d with ygiene the Mea	15. Decedents Statistical Secretarian Secretarian Statistical Secretarian Se										Maider		Industry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica FO Be Complé	Earl Bellamy Emma Kelly											27	
Should Should Me and Me and Me I is ma I To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z 6424 Fast Pratt Street Apt. 302 Baltimore, Maryland												
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposition												
Baltimore, permit. Pages I ar Department of Hee Important: If ite	1 Burial 2 Donation 5	Cremation 3 Other Specify		1 State	crematory or oth outus Me		1 Pa	ark 5	/21/	2011	A	butus, N	Marvland
altir mit. P partme portal ury or	21. Signature of Fu			F	22. N	ame and A	ddress c	of Facility	Chatn	ran-Hari	ris I	Tuneral Ho	e
1	23a. Part I. Enter th	1 / 1 /	ve-									Aryland 21	215 Approximate Interval
Physician //Medical	failure. List on	ly one cause on ea	ach line.			ie mode or	uyirig, si	uu as can	diac or i	espiratory ar	1631, 311	ock, of float	Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Gastrointestinal Hemorrhage Due to (or as a consequence of):												
<u>.</u>	Sequentially list co	naitions,	Liver Cirrhos		0								
in air	if any, leading to in cause. Enter Unde (Disease or injury to	erlying Cause	Chronic Etha	nolism									
EX B ist	events resulting in		Due to (or as a c	onsequence o	f):								
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b. Box 6876. The death certificate the death certificate by the attending phyched for use as the bysician/M.	past 12 months	?	1 Live birt	h nt at time of de	noth -	tal death her <i>(Specif</i>	_	_Ectopic p	regnand	у		Month I	Day Year
BOY e death the att	1 Yes 2 1		9 Unknow							1	\perp		
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Records, The law requires finate has been significate to the seen significate to the seen significant because a completed completed.					_						ormed?	death?	completion of cause of
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f Vital Physician ar this certi	examiner? 1 ✓ Yes	2 No	Hospital: 1 🗸 Inp	oatient 2	ER/Outpatient	3 🗌 DO	A O	Other				ence 6 Othe	n
Division of Vital Records, P.O. tal or Attending Physician: The law requires that th rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P	27. Manner of Deat		28a. Date of (Month, D	Injury ay,Year)	28b. Time of I	· ·		at Work?	- 1	8d. Describe	how in	jury occurred	
Sior Attend r death ector: by the	2 Accident	5 Pending Investigat	28e Place	of Injury - At h	ome farm stree					8f Location	Street	and Number or Ru	ıral Route Number, City
Division or spital or Attending nours after death. neral Director: After filled in by the fune. Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide 4 Homicide Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Roor Town, State)												
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the fledical Certification: To Be Completed by Physician/IM.	29a. Certifier (Check only one) 2	Certifying Physic Medical Examine	r:On the basis of	examination a	ge, death occur and/or investigat	red at the ti	me, date	e and place death occu	e, and di	ue to the cau	ise(s) e and pl	nd manner as stat ace, and due to th	ed. e cause(s)
To To Com	29b. Signature and	III-	and manner_sta					number				Date signed (Mo	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month Zi ()6:55 AM VIRGINIA MIRAMOR 2211 BARNES Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTRY HUNDRO SANFRA COLUMBIA INSPITAL If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 219-74-9979 1 □ M 2 🖔 F Days Hours July 31 71967 43 Director Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If frem 27 is marked other than "natural", or them only or other trainment. ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Howard County Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral United States 8415 Arctic Circle Drive 20794 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15, Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Field Medical Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Arthur Haines, Sr. Arlene Regina Ellis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Roland Haines (Brother) 1407 Bowles Terrace, Forest Hill, Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Berkley Cemetery 4 Donation 5 Other (Specify) May 26,2011 Street, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services—BelAir 3 Newport Drive, Forest Hill, Maryland 21050 Leave of Jen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIL SINZE **∲frysician**, disease or condition resulting in death) 12 HRS Medical Due to (or as a consequence of) Examiner buennouse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that iii titotal avent. Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ THRONGO CY TOPENIA 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No DERMATS MYOSITHS 24a Was an cate has page 2 s autopsy performed? After this certificate funeral director, pag Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 🗌 No 1 Empatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: / 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) 036974 SM 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID O. NYANTOM NO 21544 10710 COMPATED DR 6 310 wounder mo 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar